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Operation C.N.A.

Editor's Note: The highlights from the brainchild of the Registered Nurses' Association of Ontario, called "Operation C.N.A.," are reproduced here to bring the Structure Study to life for those of us not fortunate enough to have seen the production in its original form. As presented at the 1953 annual meeting of the R.N.A.O., it was a striking example of the vivid effect of visual imagery and left a deep impression on all who saw it. Unfortunately, much of this effect is lost in the printed page, as the impact and shadowing of personality as evident in the spoken word, are lost in print. However, the meaning and significance are still there for our benefit—can you imagine the rest?

On the stage were the narrator, Mrs. Helen Tucker, the author of the script, Miss H. G. McArthur, president of the C.N.A., Miss F. H. M. Emory, and Sister M. de Sales, with microphones. Mrs. Tucker is a lecturer in Oral Expression at the University of Toronto. This material is reprinted in substance from the R.N.A.O. *News Bulletin* (June, 1953).

MRS. TUCKER: It is good when a national organization can look at itself and say, "We are aware of the need for a total re-examination of our structure." This attitude bespeaks maturity, for as Matthew Arnold put it, "Not a having and a resting, but a growing and a becoming, is the character of perfection as culture conceives it." The Canadian Nurses' Association is not content to have, to be, to rest; it insists upon growing and becoming. The Structure Study of the C.N.A. is the result of that attitude and philosophy. An inquiring look at the Structure Study is the purpose of "Operation C.N.A."

Miss Emory, you've been working for a long time with this Study, haven't you? Tell me, how did it all come about?

Miss Emory: Yes, Mrs. Tucker, I have been working with the Structure Study for some time. I was the chairman of the Interim Committee which reported to the Executive Committee at the biennial meeting in 1950. There were many opportunities for service through the C.N.A. that we hadn't developed, such as the promotion of nursing education and government support; the interpretation of nursing to nurses; studying and recommending better functioning of committees, and building more effective cooperation between the national and provincial bodies.

Mrs. Tucker: The biennial meeting must have accepted your report then, in 1950?

Miss Emory: Yes, it did, unanimously, and a Structure Study Committee was set up. Dr. Pauline Jewett was chosen as director.

Mrs. Tucker: She completed her report and presented it to your committee in January, 1952 . . . I confess I am impressed by Dr. Jewett's Structure Study Report and I am even more impressed by the progressive approach your members have made to the solution of its organizational problems. However we may state it, the simple fact remains that no one lives unto himself alone. Each is a part of a large segment, a part of a whole stretching beyond imagination (*Fig. 1*).

> The nursing profession in Canada, knit together in the Canadian Nurses' Association, is a complex but unified segment which begins with *you* — the Registered Nurse. You and you and you choose to work together for common purposes into more and more complex units—the local chapters, the district, the provincial associations—then on to the C.N.A., the national structure, which in turn carries you forward as an instrument of intelligence, goodwill and service into the International Council of Nurses. Just think, civilization itself rests upon our ability to organize ourselves into more and more complex but coordinated segments of the whole, each orderly, each with function and purpose. Doesn't that make you feel a kind of tingly thrill? It should; that's the realization of maturity.

Mrs. Tucker: There are five basic concepts in the recommendations of the report. Miss Emory, what are these basic concepts or considerations?

Miss Emory: (1) It is the function of the national organization to formulate national policies and to have an advisory relationship with the provincial groups which are self-governing units.

(2) The composition and the number of the Executive Committee of the C.N.A. should be changed, the provincial groups having *membership* rather than *representation* (this is true also of the sisterhoods), with the total number reduced.

(3) The committee structure should be rearranged in point of function and number.

(4) The personnel at the National Office should be increased.

(5) The implementation of the recommendations can be made step by step.

Mrs. Tucker: The accompanying diagram shows the proposed composition and number of the Executive Committee. Sister de Sales, would you tell us how it is suggested that this committee be made up?

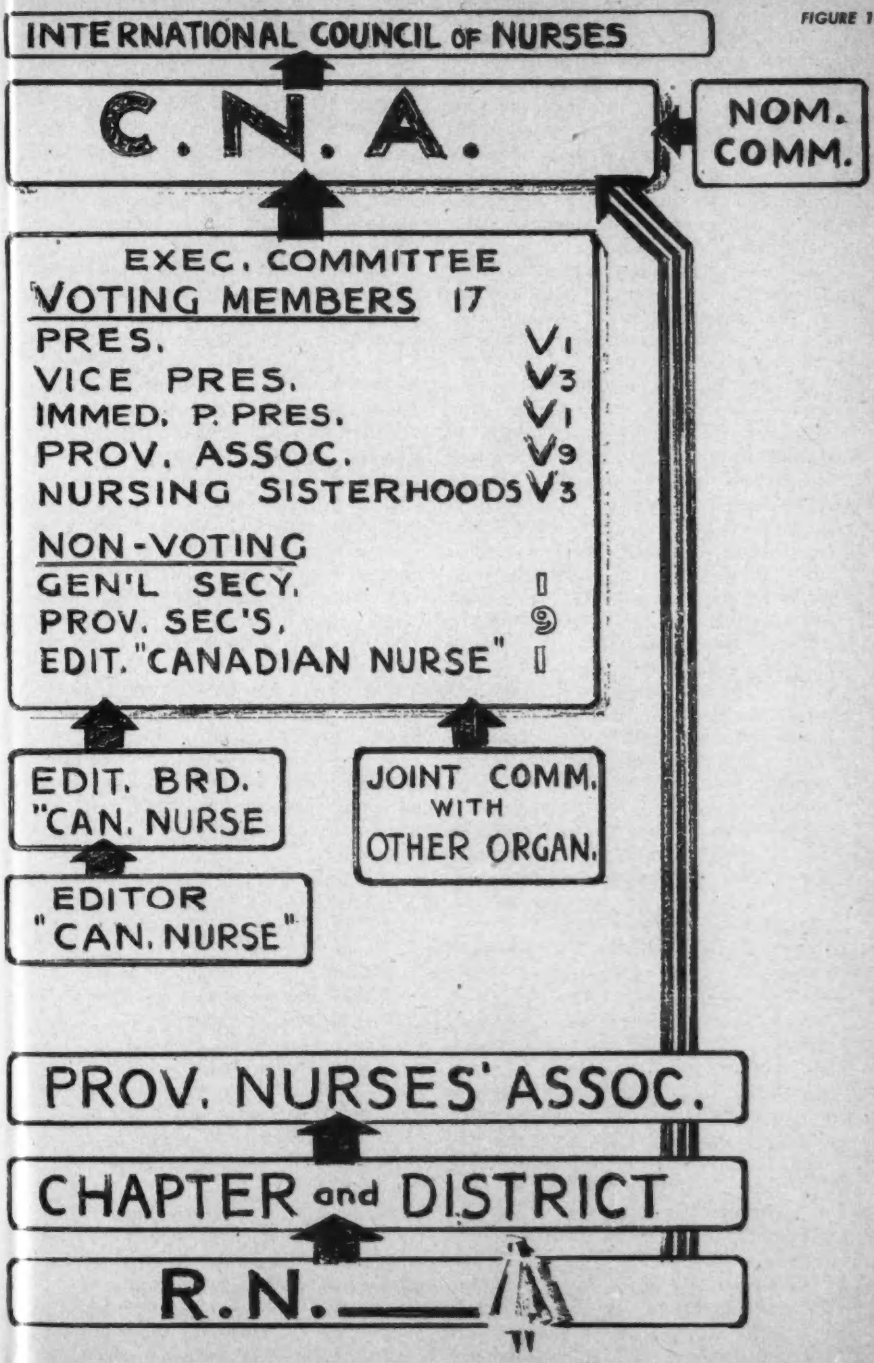
Sr. de Sales: The committee is to be composed of 17 voting and 11 non-voting members, Mrs. Tucker. The voting members are the president, three vice-presidents, the immediate past president, one member of the association from each province, and three members from the nursing sisterhoods . . . The non-voting members are all professional staff people—the hired servants of the C.N.A. They are research people and advisers but they don't make policy or the rules of administration.

Mrs. Tucker: How does the proposed Executive Committee compare with the present one in numbers?

Sr. de Sales: Seventeen voting members as opposed to the 33 we now have. The most important change here is in the principle of membership. The "provincial people" on the committee are no longer *representatives* from their provincial associations but *members* of the Association from their respective provinces. The same is true of the nursing sisterhoods. This is much more than a change in wording; it implies a change in spirit. The "provincial people" are no longer to be thought of as *representing* any particular province or group, any more than elected officers do.

Mrs. Tucker: What you are saying, then, is that the voting membership who sit on the Executive Committee will *all be national people* who represent, not provincial associations, but various points of view in the field of nursing.

FIGURE 1


INTERNATIONAL COUNCIL OF NURSES
C. N. A.
NOM. COMM.
EXEC. COMMITTEE
VOTING MEMBERS 17
PRES. V1
VICE PRES. V3
IMMED. P. PRES. V1
PROV. ASSOC. V9
NURSING SISTERHOODS V3
NON-VOTING
GEN'L SECY. 1
PROV. SEC'S. 9
EDIT. "CANADIAN NURSE" 1
EDIT. BRD. "CAN. NURSE
JOINT COMM. WITH OTHER ORGAN.
EDITOR "CAN. NURSE"
PROV. NURSES' ASSOC.
CHAPTER and DISTRICT
R.N.

Miss McArthur: The Executive Committee has been reconstituted in such a way that its voting members are all on it as *national* people. With none of the voting members representing provincial associations (in particular), there will no longer be any feeling of obligation, on their part, to refer proposed policies to the provincial associations first. As national people, they will refer then directly to the voting delegates. As a result, both the content of the national policies and the mechanics of their formulation will be greatly improved.

Sr. de Sales: The aim is *individual* membership rather than representation of a group. The mark of a mature organization is that its members feel free to change their minds *after* hearing discussion and points of view from other parts of the country. The members realize, of course, that the recommendations which the national group make do not commit any provincial organization because the provinces are self-governing units. The C.N.A. is an advisory body only.

The "Joint Comm. with other organ." on the chart means, of course, "joint committees with other organizations." It means that members of the Executive Committee serve on committees with other organizations, such as, governmental committees concerned with public health or civil defence. It's another way we have of informing ourselves so that our policies will be truly national in scope.

Mrs. Tucker: Are there any changes proposed for the nominating committee of the C.N.A.?

Miss Emory: The nominating committee is increased from 5 to 10 members, one member appointed by each provincial association. This is really a simplification and there is no difficulty in selecting a chairman since the immediate past president is automatically chairman. Also there are some very interesting changes proposed for the sub-committee of the Executive Committee.

Mrs. Tucker: I see by *Fig. 2* that the sub-committee, too, is made up of voting and non-voting members. Miss McArthur, it shows the professional staff as rather a strong underpinning for the sub-committee. What is the relationship?

Miss McArthur: The composition of the sub-committee represents a very important change. The second and third vice-presidents and the four members from the provinces and sisterhoods are chairmen of six national committees. This idea is new.

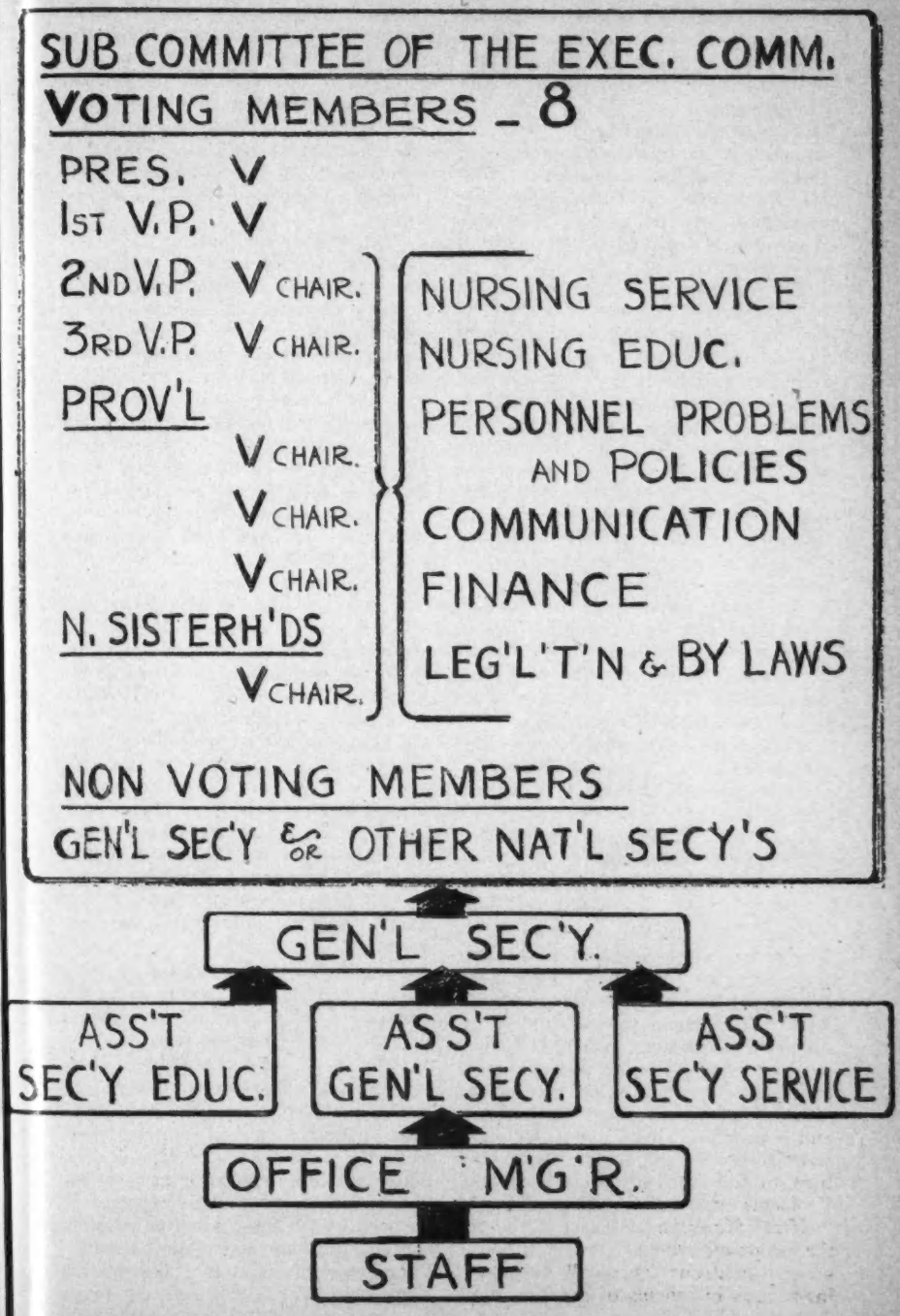
You may know that the function of the sub-committee is to administer the affairs of the Association between meetings of the Executive Committee. This means that this committee has a lot of the policy formulating work to do at the groundwork stages and this requires thoroughness and detail. Bear in mind that we are dealing with policies in nursing service, nursing education, and employment relations and, at the same time, we are conducting a network or clearing house of information, advice, and assistance for the provincial associations, the membership at large, the International Council of Nurses, other organizations, and the public generally.

The Study has pointed out that the work of this network can be conducted more efficiently and effectively by changing our national committee structure from a vertical to a horizontal plan. Let me illustrate. At the present time there are eleven national committees:

1. Committee on Institutional Nursing.
2. Committee on Private Nursing.
3. Committee on Public Health Nursing.
4. Committee on Health Insurance.
5. Committee on Educational Policy.
6. Committee on Finance.
7. Committee on Labor Relations.
8. Committee on Program.
9. Committee on Constitution, By-laws and Legislation.
10. Committee on Arrangements.
11. Committee on Student Nurse Activities.

Some of the committees are organized on the "vertical" principle—that is, some of them are concerned with *all* matters affecting a particular group of nurses. The institutional nursing committee, for example, might be concerned with the education, service and

FIGURE 2


SUB COMMITTEE OF THE EXEC. COMM.
VOTING MEMBERS - 8
PRES. V
1ST V.P. V
2ND V.P. V CHAIR.
3RD V.P. V CHAIR.
PROV'L
V CHAIR.
V CHAIR.
V CHAIR.
N. SISTERH'DS
V CHAIR.
NURSING SERVICE
NURSING EDUC.
PERSONNEL PROBLEMS AND POLICIES
COMMUNICATION
FINANCE
LEG'L'T'N & BY LAWS
NON VOTING MEMBERS
GEN'L SEC'Y & OR OTHER NAT'L SECY'S
GEN'L SEC'Y.
ASS'T SEC'Y EDUC.
ASS'T GEN'L SECY.
ASS'T SEC'Y SERVICE
OFFICE M'G'R.
STAFF

personnel policies of all nurses in institutions; the private nursing committee concerned for private nurses; and public health nursing committee for public health nurses.

This wouldn't be true, however, for committees on educational policy, for instance, and labor relations. These are "horizontal" committees that are concerned with policy for all nurses, regardless of their particular fields of professional activity.

We feel that the committees should be reorganized on one principle and one principle only. Some might want to see the vertical principle applied right across the board, but that would lead to an even greater stratification between groups of nurses than now exists, and an even greater difficulty in getting them to see and to understand one another's point of view. The alternative, therefore, is to organize all committees on the horizontal principle —a principle that has merit in its own right since *it stresses what unites rather than what divides.* To do this, it is proposed to blend the present committees. From them will be formed six national committees that will serve the interests of all groups more effectively. These committees are:

1. Committee on Nursing Service.
2. Committee on Nursing Education.
3. Committee on Personnel Problems and Policies.
4. Committee on Communication.
5. Committee on Finance.
6. Committee on Legislation and By-laws.

Mrs. Tucker: For example, Miss McArthur, let us say that if the matrons of small hospitals need some advice on the role of the auxiliary nurse, they would turn to the Committee on Nursing Service; if they need guidance on organizing staff education courses, they would turn to the Committee on Nursing Education; and if they need help in establishing a wage scale for their nurses, they would turn to the Committee on Personnel Problems and Policies. Am I right?

Miss McArthur: Exactly. Under the proposed scheme all the different groups—matrons of small hospitals, instructors in schools of nursing, head nurses, industrial nurses, private nurses and so on—would know that they had three committees to look after them, one each in the fields of service, education, and personnel problems and policies. Thus their particular interests would be more effectively served and, at the same time, their common problems more effectively shared.

The fourth committee, the Committee on Communication, will be an added guarantee that the needs of particular groups will at no time be overlooked. This committee would handle the program arrangements and publicity for biennial meetings. In addition, it would take over the activities of the present student nurses' committee and of the present public relations committee. Further, it would in general "keep its ear to the ground" for suggestions and complaints and keep the membership informed about C.N.A. activities.

Mrs. Tucker: I presume, Miss McArthur, that the Committee on Communication would, as the external side of its function, work closely with the president and the general secretary and with any joint committees to ensure that the I.C.N., other associations, the government and the public are as up to date as possible with developments in Canadian nursing.

Miss McArthur: That's correct, Mrs. Tucker. There is no change proposed for the committees on Finance and Legislation and By-laws excepting that the Finance Committee would have a few additional responsibilities such as looking after loans and bursaries.

Mrs. Tucker: Now, let us return to our sub-committee structure. The second and third vice-presidents and the four members from the provinces and sisterhoods are the chairmen of these proposed six national committees.

Miss McArthur: Right. The chairmen of the six national committees are to be the six members of the sub-committee who do not occupy the positions of president and first vice-president. As soon as the sub-committee is established at the meeting of the Executive Committee immediately following the biennial, it will hold a meeting of its

own and its members shall decide among themselves how the committee chairmanships shall be distributed. They shall then inform the other members of the Executive Committee and the Association as a whole of their decisions.

Sr. de Sales: Miss McArthur, won't these six sub-committee members have too much to do with these committee chairmanship jobs as well? Some of them might be presidents of their own provincial associations besides.

Miss McArthur: It might seem so but the chairmanship jobs aren't really as heavy as they appear. Whereas the committee chairman will supervise the studies and demonstrations undertaken, the actual research work will be done by special committees and the permanent staff in National Office, which is to be increased by an assistant secretary on Education and another on Service. The major function of the committee chairmen is to provide overall integration of committee activities, in cooperation with the president and the first vice-president.

Miss Emory: Miss McArthur, it should be pointed out that a special committee may be set up at any time by a national committee to do a specific piece of work. It would consist of very able people regardless of their particular field of nursing. It might take two weeks or two years or longer to fulfill the task for which it was formed. Once it had completed its work and given its report to the parent committee, it would be dissolved. There might be a dozen such special committees in existence at any one time.

Mrs. Tucker: These special committees would be assisted by the assistant secretaries who naturally would be well trained in research.

I can see, Miss McArthur, that this sub-committee reorganization tightens the whole machinery of the C.N.A. It gives the vice-presidents good training and it ensures a closer, better integration of committee activities since the integration will be provided by a small group.

Perhaps now we should review the relationship of the C.N.A. with the provincial associations in the light of its basic function—formulating national policies. It wouldn't do for us to be like the pilot who said, "I may be off course but I've sure got good speed." We want to be clear on what the goal is as well as how to get there.

Path of Policy

The policies of the Canadian Nurses' Association, we may be sure, don't start in a vacuum. They begin with an idea—an idea in somebody's head. Before that idea can become policy, it must set up a chain reaction that follows a structural route. On the way the idea passes from one nurse's mind to another; it is discussed, evaluated, modified, enlarged, clarified and finally formulated.

The root of C.N.A. policy is an idea, perhaps a tiny atom of insight into some aspect of nursing education. This golden idea may first occur in *your* mind. You keep thinking about it; you bring it out in casual conversation at one of your chapter meetings. Your fellow nurses think it has merit. They suggest that your idea be carried forward, that it be started on the way to the C.N.A.

Your idea travels from local consideration to the district. Perhaps it may be diverted to the committee on nursing education or the district executive may receive it and, after evaluating its merits, turn it over to a special committee. It is worked over and put into shape for presentation to the provincial association. Now, under the present structure, your idea could go no further unless adopted by the province. Under the proposed plan your idea bypasses *acceptance* by the provincial association and travels right along to the C.N.A.

Let us say you take it to the chairman of the Committee on Nursing Education. She is a member of both the Executive and the sub-committee. Your idea is going to get consideration. Perhaps the Committee on Nursing Education chairman will ask that a special committee be set up to work with the assistant secretary on education from the permanent staff. The chain reaction has set in. Opinions are

sought from provincial people all over the country—consultations, research, meetings, conferences seeking out knowledge and information from those people who are in a position to know. Finally the sub-committee presents your golden idea, shaped and formulated, to the National Executive Committee which agrees to place it before the biennial meeting. There its fate is determined by the voting delegates. If accepted, your tiny atom of insight explodes into the golden rays of C.N.A. policy. They fall upon the members of the Registered Nurses' Associations—in the provinces, in the districts, in the chapters—and upon the general public. An umbrella is raised over the provincial associations, however, because there C.N.A. policy is advisory only. The provinces are self-governing units, free to implement only what to their association seems wise, or what is possible within the laws of the province. The province is free to refuse or to accept, by raising or lowering its umbrella to the rays of C.N.A. policy.

The Path of Policy that I have just described is *not* the route that you are following at the present time. Whether or not you adopt this Path of Policy depends upon how the annual meeting next year instructs its delegates to vote at the 1954 biennial meeting in Banff. Now it's up to you!

Questions and Answers

Q. According to the proposed plan, the number of voting members of the C.N.A. Executive is reduced to 17. That's a lot of voting power in the hands of a few people. How is this concentration of power to be avoided?

A. In the first place, these 17 people would be a very representative, mature group and not likely to abuse power. On the other hand, concentration of power is avoided by restrictions on the individual terms of office and also the total number of years a voting member of the Executive may remain on the Committee.

> All voting members of the Executive Committee shall, if possible, hold office until the conclusion of the next general meeting after their elevation to office. No officer shall be elected to the same office for more than two consecutive years. No other voting member of the Executive Committee shall hold the same office for more than four consecutive years. With the exception of the past president, no voting member of the Executive Committee shall remain on the Executive for more than eight consecutive years.

Q. Will the proposed change in structure threaten the authority of the provincial associations? Yes or no?

A. No! The C.N.A. advises; the provinces implement only if they choose to do so.

Q. What happens to the special interest committees under the new committee structure?

A. Most of them will find a home in one of the six national committees. Of course, special interest committees may, and will, exist under one of the six national committees. The new Committee on Communication with its "ear to the ground" will be looking after special interests of either individuals or groups of nurses and will serve as the channel of information, advice, complaint and suggestion for the whole network—internal and external.

Q. Would any legal changes be required to adapt this structural reorganization?

A. Minor changes in the present Act of Incorporation will have to be made but these can be made at a later date. According to legal advice, the main changes recommended can be carried out by amendment of the by-laws of the Association at a general meeting providing three months' notice is given.

Q. Who votes on what at the biennial meetings under the new structure?

A. We can describe it briefly this way:

> (1) Officers would be elected by voting delegates who would come to the biennial meeting planning to support the nominations presented by their provinces. You might say that delegates voting for officers would be instructed by their provincial associations.
>
> (2) Matters of policy would be voted upon by the voting delegates.

(3) Matters of non-policy would be voted upon by the general membership.

Q. How is C.N.A. membership defined in the Structure Study?

A. Membership is defined by the provincial associations in their legal Acts. An ordinary member of the C.N.A. is any nurse who is a duly qualified member in good standing of any of the provincial associations.

Q. Can the Association *afford* to increase staff as this study suggests?

A. It is better put the other way about—we can't afford *not* to increase the staff at the National Office; that is, if the C.N.A. is to fulfill its functions properly.

Q. Is the C.N.A. always advisory according to the Structure Study or could it sometimes be directive?

A. Implementation of policy is the responsibility of the provincial associations. However, there are a few matters on which the Executive Committee may wish a national policy to be implemented by the provincial associations immediately following a biennial meeting. On such a matter, for example, as a proposed raise in the C.N.A.'s annual membership fee, the Executive Committee would first have to secure a commitment from the provincial associations. Then, at the time of a biennial meeting, the voting members would be in a position to implement the policy.

Q. Is there any reason for leaving the past president off the sub-committee of the Executive?

A. This suggestion seems to be in line with the general recommendation of limiting the length of term in office. Also, this helps to keep the sub-committee small in number and still provide for broad representation. The past president is suggested as chairman of the nominating committee where her experience would be used in seeking the best possible candidates for office to serve the membership.

Q. Was that Study worth all the money the C.N.A. spent on it?

A. The C.N.A. looks at it this way. Is it worth the price of a package of cigarettes per member to have all members of the C.N.A. read, study and understand their present constitution? The C.N.A. thinks it is. We think, too, of course, that the recommendations of the Structure Study have been made only after very careful consideration and research and whatever changes may come will represent an ample bonus on our investment.

The Younger Generation

I have just returned from my holidays, and, whilst I was walking down the drive of the hospital on the first morning of my return, the loveliest feeling of satisfaction swept over me, for I was once again returning to take up something which I love very much — that is my nursing. I am one of the so-called "younger generation," over whom older men and women are inclined to shake their heads, yet I am sure that there are many other young nurses who feel as I do about the nursing profession. We hear it said many times that nursing is hard work, yet I have never found it so, for I have always believed that anything one enjoys doing cannot be hard work.

Why do I not go in for one of "those five-day-week jobs," with a nice wage waiting at the end of it? I know that that wage, which many people consider so important, could not purchase the happiness which I receive each day in my present profession. There is the joy of seeing patients who, after being so ill, return home to their families and loved ones. What of those who do not return home? We still have the satisfaction of knowing that we were there when they needed us most — for when is the need greater than at that time?

I hope that these few words may bring comfort to those older members of our profession who have shaken their heads over the "younger generation" and help them to know that there are some of the younger members of the profession who become student nurses because they desire to serve others.

—A Student Nurse in *Nursing Mirror*

Treatment of Injuries to the Eye

CLEMENT MCCULLOCH, M.D., R. G. C. KELLY, M.D., HARRY M. MACRAE, M.D.

FIRST AID WORKERS going into a devastated area will see five types of injuries to the eyes: foreign bodies and lacerations, contusions, damage due to burn by heat or short waves, or damage due to poisonous gases or other noxious chemicals. These injuries may occur from various causes, such as from an atomic bomb, from ordinary explosions, or from fires. In one area, or in one patient, there may be several types of trauma occurring at one time.

In every case suffering from a foreign body in, or a laceration of, the eyeball, decide two points. Is the injury penetrating or is it non-penetrating? Is the cornea grossly affected or is it not damaged? The cornea is the clear window lying in front of the colored part of the eye. If the patient is having pain or discomfort in the eye the cornea is probably affected: if the patient is not suffering the eye may be severely injured but at some other point than at the cornea.

PENETRATING WOUNDS

Wounds, and foreign bodies that pass into the interior of the eyeball, do so through the sensitive cornea, or through the relatively insensitive white of the eye. The eyeball will be collapsed if the wound is large but may be intact if the wound is small. If the entrance is through the cornea the pupil may be displaced towards the wound. If entry is through the white of the eye the opening to the interior may not be visible on casual inspection. When the eyeball has been penetrated cover with a pad and send the patient to the first aid station for direct routing to the nearest ophthalmic unit. Perforations of the eyeball are injuries that should reach the ophthalmic unit as soon as possible and that should not be tampered with before that time. This statement applies whether there is a penetrating laceration of, or a foreign body inside, the eyeball. If the eyeball is soft the patient should be transported by stretcher.

NON-PENETRATING WOUNDS

Lacerations and foreign bodies that do not enter the eye are more common than those that are penetrating. If the eye is painful the cornea is involved; Tetracaine ointment will relieve the pain. Cover the eye with a pad. The patient should be able to walk back to the first aid station. If the eye is not painful, but you can see a foreign body or a laceration, instruct the patient to report to the first aid station.

CONTUSIONS

An eyeball may be severely injured by direct force, without being perforated. This can occur when a blunt object strikes the eye with considerable force and will be evidenced by pain, loss of vision, or blood lying over the dark of the eye. Patients with such an injury should walk, or can proceed by a convenient mode of transportation, to some place where they can be immobilized, in bed, and seen by an ophthalmologist.

BURNS FROM HEAT

Many burns, whether from short or long waves, cause great discomfort but, ultimately, are not serious. The patient needs relief from pain. Instil Tetracaine ointment and instruct the patient to report to the first aid station. Severe burns of the eye will usually be seen in patients who have extensive burns elsewhere, particularly on the face. Such a patient will go to the first aid post and from there be sent to a larger treatment centre. Treatment of

The authors are all on the staff of the Department of Ophthalmology, University of Toronto. This article is the fifth of a series to be reprinted, with permission, from the special issue for Civil Defence, published by the *Canadian Medical Association Journal.*

the general burn will, likely, be your first concern. Put some Tetracaine salve in the patient's eyes and have him transported to the first aid station.

Chemicals

If a harmful chemical, such as mustard gas, a "nerve" gas, acid, or caustic, has entered the eye, wash immediately, with copious amounts of water from your canteen bottle. Open the lids to allow the water to flow next to the eyeball and behind the upper and lower lid. Instil Tetracaine salve and send the patient to the first aid station.

The first aid worker should label patients as "eye injury" or "serious eye injury." A serious eye injury is a laceration or foreign body which has penetrated the eyeball, a contusion or a severe burn.

At the first aid station handle the cases according to the following program. In general, if the injury is such that healing will be complete in two days the final treatment can be given. If recovery will take more than two days refer the patient to the nearest ophthalmic unit,

At the Treatment Centre

Patients with an *intraocular foreign body,* or with a *laceration* which perforates the globe, should go to the nearest ophthalmic unit. Do not disturb any gaping wounds of the eyeball. A patient with a soft eye should go on a stretcher.

When a *foreign body is present* in the cornea instil Pontocaine ½% drops until the cornea is anesthetized. With a spud lift off, cleanly, the foreign body. Put some Tetracaine ointment in the conjunctival sac. If the removal was difficult cover the eye with a pad. If the foreign body came away leaving but a small abrasion the eye may remain uncovered. Unless the wound is trivial an eye with a non-penetrating laceration of the cornea should be covered with a pad.

When foreign bodies lie on the white of the eye, or under the upper or lower lid, anesthetize with drops of Pontocaine ½% and remove the particles. Instil Tetracaine salve. A non-penetrating laceration over the white of the eye is not an indication to cover the eye with a pad. Only when the injury is severe should the eye be covered with a pad or should the patient be sent to the nearest ophthalmic unit.

Burns of the eye will usually be seen in patients who have generalized burns. Treatment of the eyes will need to be integrated with the treatment of the more widespread burn. Instil Tetracaine salve. If the injury to the eye is at all severe the patient should be forwarded to the nearest ophthalmic unit. If the patient is going to a centre for the treatment of his burns he should be labelled with a tag indicating that he has an injury to his eyes.

Mild burns of the eyes cause a lot of pain and photophobia but heal quickly with no complications. A patient with a lot of pain and photophobia, but with the history of only a mild burn, showing only slight edema of the lids and little damage to the eyeball, may be of this type. You may need to instil Pontocaine ½% drops to see the eyeball. If the eye appears in good order instil Tetracaine ½% salve, cover the eye with a pad, and instruct the patient to remove the pad in 48 hours.

Insult to the eye by *poisons or caustics* should be treated at once. Wash the conjunctival sac of the affected eye continuously for five minutes with clean water. Turn the upper and the lower lid and remove any foreign material found on the inner surface. Instil Tetracaine salve. Many of these cases will be serious, and will need to be referred to an ophthalmic unit.

If droplets of one of the so-called "nerve gases" have fallen in the conjunctival sac the patient will have pain about the eye or headache, blurred, dim or dark vision, and a small pupil. Wash the conjunctival sac and instil atropine expressed from a syrette. In all but mild poisonings further treatment will be given at a hospital.

Soar to the Heavens — in the Chair-Lift — at Banff Biennial, June '54.

Le Traitement des Blessures aux Yeux

CLEMENT MCCULLOCH, M.D., R. G. C. KELLY, M.D., HARRY M. MACRAE, M.D.

LES SECOURISTES, en pénétrant dans une région dévastée, pourront observer, aux yeux des victimes, cinq sortes de blessures: des inclusions de corps étrangers, des lacérations, des contusions, des brûlures causées par des ondes calorifiques ou des ondes courtes, et des lésions causées par des gaz toxiques ou d'autres produits chimiques nocifs. Ces blessures peuvent avoir pour origine diverses causes, l'explosion d'une bombe atomique, celle de bombes ordinaires, ou l'incendie. Dans une même région, plusieurs sortes de lésions traumatiques peuvent se produire simultanément, de même que chez une victime en particulier.

En face de chaque lésion causée au globe de l'œil par un corps étranger ou par une lacération, il faut trancher deux questions: la lésion est-elle perforante ou non?, la cornée est-elle gravement atteinte ou est-elle intacte? La cornée est la fenêtre transparente qui recouvre la partie colorée de l'œil. Si le blessé ressent une douleur ou un malaise à l'œil, la cornée est probablement en cause, tandis que s'il ne ressent pas de douleur, l'œil peut être blessé gravement, mais en un autre point qu'à la cornée.

LESIONS PERFORANTES

Les plaies, et les corps étrangers qui pénètrent jusqu'à l'intérieur du globe de l'œil, traversent la cornée sensible ou le blanc de l'œil relativement insensible. L'œil s'aplatit si la plaie est grande mais il peut garder sa forme si la plaie est petite. Si la perforation s'est produite à travers la cornée, la pupille peut être déplacée vers la plaie. Si elle s'est produite dans le blanc de l'œil, elle peut passer inaperçue lors d'un examen rapide. Si l'œil est perforé, on le recouvrira d'un pansement et on dirigera le blessé vers le poste de secourisme, d'où on l'enverra à l'unité ophtalmologique la plus rapprochée. Les perforations de l'œil sont des blessures qui doivent être soumises à l'unité ophtalmologique aussitôt que possible et auxquelles il ne faut pas toucher jusqu'à ce moment. Ces directives s'appliquent quelle que soit la cause de la perforation de l'œil, une lacération ou un corps étranger. Si le globe de l'œil est mou, il faut transporter le blessé sur un brancard.

PLAIES NON PERFORANTES

Les lacérations superficielles, et les corps étrangers qui ne pénètrent pas dans l'œil, sont plus fréquents que ceux qui causent une perforation. Si l'œil est douloureux, la cornée est en cause; un onguent contenant de la tétracaïne soulagera la douleur, puis on recouvrira l'œil d'un pansement. Le blessé devrait pouvoir se rendre à pied au poste de secourisme. Si, bien que l'œil ne soit pas douloureux, on peut voir un corps étrangers ou une lacération, il reste à diriger le blessé sur le poste de secourisme.

CONTUSIONS

Le globe oculaire peut être gravement lésé par un choc direct sans qu'il y ait de perforation. C'est ce qui se produit lorsqu'un objet contondant frappe l'œil avec beaucoup de force; le blessé ressentira alors de la douleur, ne pourra voir de cet œil, ou aura la pupille de l'œil obstruée de sang. Les victimes de ce genre de blessure devraient pouvoir se rendre à pied, sinon par quelque moyen de transport, à un endroit où on pourra les immobiliser au lit et les confier aux soins d'un ophtalmologiste.

BRULURES D'ORIGINE THERMIQUE

Beaucoup de brûlures, qu'elles

Les auteurs sont membres du Département d'Ophtalmologie, Université de Toronto. Ceci est le cinquième d'une série d'articles du numéro spécial du *Canadian Medical Association Journal* sur la Défense Civile qui seront publiées avec la permission de l'Association Médicale Canadienne.

soient dues à des ondes courtes ou longues, causent beaucoup de malaise, mais elles ne sont pas graves en fin de compte. Ces brûlures réclament un soulagement de la douleur. On appliquera un onguent contenant de la tétracaïne et on enverra le blessé au poste de secourisme. On observera ordinairement des brûlures graves des yeux chez les victimes ayant subi des brûlures étendues sur d'autres parties du corps, en particulier au visage. On dirigera ces blessés sur le poste de secourisme, d'où on les évacuera sur un centre de traitement plus important. Le traitement général des brûlures sera probablement le premier souci du secouriste. Appliquer de l'onguent de tétracaïne dans les yeux du blessé et le faire transporter au poste de secourisme.

Produits Chimiques

Si un produit chimique dangereux tel que le gaz moutarde, un gaz névrotique, un acide ou un alcali a pénétré dans les yeux, laver ceux-ci sur-le-champ à grande eau provenant du bidon. Soulever les paupières afin de laisser couler l'eau sur le globe oculaire et en dedans des paupières. Appliquer de l'onguent de tétracaïne et envoyer le blessé au poste de secourisme.

Sur l'étiquette des blessés, le secouriste doit inscrire "blessure aux yeux" ou "blessure grave aux yeux." Seront considérés comme blessures graves aux yeux une lacération ou un corps étranger ayant causé une perforation, une contusion, ou une brûlure grave.

Au poste de secourisme, on fera le tri des victimes selon le programme ci-dessous. Règle générale, si la blessure est assez légère pour que la guérison soit complète en deux jours ou moins, on entreprendra le traitement définitif. Si la guérison exige plus de deux jours, on enverra le blessé à l'unité ophtalmologique la plus rapprochée.

Au Centre de Traitement

Les victimes *d'une perforation de l'œil* par un corps étranger ou par *une lacération* seront envoyées à l'unité ophtalmologique la plus rapprochée. Ne toucher à aucune blessure béante du globe oculaire. Tout blessé ayant un œil mou devrait être transporté sur un brancard.

Si l'on découvre *un corps étranger* dans la cornée, instiller dans l'œil des gouttes à ½ p. 100 de pontocaïne jusqu'à ce que la cornée soit insensibilisée. Enlever proprement le corps étranger au moyen d'une curette. Introduire de l'onguent de tétracaïne dans le cul-de-sac de la conjonctive. Si l'enlèvement de la particule a été difficile, recouvrir l'œil d'un tampon. Si le corps étranger s'est détaché en ne laissant qu'une petite éraflure, on pourra négliger de recouvrir l'œil. On recouvrira d'un tampon tout œil ayant subi une lacération non perforante, à moins que la lésion ne soit insignifiante.

Lorsqu'il y a des corps étrangers sur le blanc de l'œil ou sous la paupière supérieure ou inférieure, insensibiliser l'œil avec quelques gouttes de pontocaïne à ½ p. 100, puis enlever les particules. Appliquer ensuite de l'onguent de tétracaïne. Une lacération non perforante du blanc de l'œil n'exige pas de recouvrir l'œil d'un tampon. On n'appliquera un tampon que si la blessure est grave ou que le blessé doive être dirigé sur l'unité ophtalmologique la plus rapprochée.

Les brûlures aux yeux se rencontreront surtout chez les personnes portant des marques de brûlures généralisées. Il faudra intégrer le traitement des yeux dans celui des brûlures étendues. Introduire sous les paupières de l'onguent de tétracaïne. Si la blessure à l'œil est quelque peu grave, on fera transporter le blessé à la plus proche unité ophtalmologique. Le brûlé qui se rend à un centre pour se faire traiter doit porter une étiquette et celle-ci doit indiquer qu'il y a blessure aux yeux.

Les brûlures légères aux yeux provoquent beaucoup de douleur et de photophobie mais elles guérissent rapidement sans complications. Par exemple, un blessé atteint seulement d'une légère brûlure, peut ressentir une vive douleur et faire de la photophobie, mais ne présenter qu'un faible œdème des paupières et peu de dommage au globe oculaire. Afin de pouvoir examiner le globe, il peut être

nécessaire d'instiller dans l'œil quelques gouttes de pontocaïne à ½ p. 100. Si l'œil semble intact, y appliquer de l'onguent à ½ p. 100 de tétracaïne, recouvrir l'œil d'un tampon, et recommander au blessé d'enlever ce tampon au bout de 48 heures.

Les atteintes aux yeux par des poisons ou des caustiques doivent être traitées sans délai. Rincer le cul-de-sac de la conjonctive de l'œil atteint, par un jet continu d'eau propre durant cinq minutes. Retourner l'une après l'autre les paupières supérieure et inférieure et enlever les matières étrangères qu'on pourra découvrir sur leur surface interne. Y appliquer de l'onguent de tétracaïne. Plusieurs de ces cas seront graves et devront être référés à une unité ophtalmologique.

Si des gouttelettes d'un des gaz appelés névrotiques se sont introduites dans le cul-de-sac de la conjonctive, le blessé ressentira de la douleur autour de l'œil, ou un mal de tête, sa vue sera confuse, faible ou presque nulle, et la pupille sera rétrécie. Rincer le cul-de-sac de la conjonctive et y instiller de l'atropine au moyen d'une syrette. Dans tous les cas d'empoisonnement, sauf dans les cas bénins, c'est à l'hôpital que se continuera le traitement.

Carcinoma of the Lung

RONALD D. NASH, M.D.

BRONCHOGENIC CARCINOMA differs from other cancers in two important respects:

It has shown an enormous increase in the last 35 years.

There has been a progressively larger incidence in the male sex.

There is no longer any doubt that this increase is real and not just apparent. Doll and Hill quote in a British Government report that "for a 25-year period from 1922 to 1947 the incidence of the condition found at autopsy has increased 15 times." In a ten-year period in the United States from 1938 to 1948 the number of reported fatalities from this disease has increased 144 per cent. During this same period reported deaths from all types of cancer have increased only 31 per cent. Cancer of the lung in many institutions is now considered to be the most frequent visceral cancer in the male patient, being more common than cancer of the stomach.

Pulmonary cancer, on the average, affects rather younger people than most carcinomas, the mean age series ranging from 45 to 55 years. Cases have been reported in children but this is unusual. However, it is not uncommon to have such patients in their late 20's.

The etiology of this disease, of course, is unknown. Chronic infections, silicosis, and various dusts have at one time or other been considered important etiological factors. In recent years it has been felt that a large number of these cases were precipitated by the inhalation of dust containing hydrocarbons. This was supported by the increased incidence among city dwellers where the air contains hydrocarbon fumes produced by motor cars, factories, etc.

Over the last 25 years various investigators have proposed that possibly the most important factor to be considered in the production of lung cancer was cigarette smoking. This opinion has gained more favor in the last few years. Wynder and Graham in 1950 reported on a large statistical study. Using control groups they found that of 605 males with bronchogenic carcinoma 96.5% had smoked more than 10 cigarettes daily for 20 years or more, compared to 73.7% of

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a control group without carcinoma of the lung. Of those with cancer of the lung 50.1% had smoked more than a package a day, while only 19.1% of those without the disease had smoked in this excess. Only 2% of those with cancer had never smoked at all or, if they had, it was less than half a package a day.

They concluded from their study that to develop cancer of the lung it is apparently necessary for a man to be a heavy smoker (at least half a package a day) and to have smoked for a long period of time (20 years).

It is argued that if cigarettes are such an important factor women (who are generally considered to be heavy smokers) should be susceptible and that the 18 to 1 male predominance of this disease should be more equal. However, in their review the doctors found, from a large group, that only 1.2% of the women were heavy smokers compared to 19.1% of the males in control groups. They found it is chiefly the girls and the young women who smoke. They have not yet had time to smoke for 20 years or more. It is to be assumed then that this disease should become more common in the females in the future.

Types

There are three pathological types of bronchogenic carcinoma:

Epidermoid or squamous-cell carcinoma.

Adenocarcinoma.

Oat-cell carcinoma.

The first two of these originate in the bronchi or bronchioles of the lung. The latter is thought to originate from the lung alveoli. It is the epidermoid or squamous-cell type that is showing the increase and is apparently related to the smoking of cigarettes. It is suggested that the adenocarcinoma arises from embryonic tissue which has failed to develop, remaining dormant for many years before being transformed into carcinoma. This type, as far as we know, is not related to cigarette smoking. The third type — the oat-cell carcinoma—is thought possibly to be related in some way to a virus infection.

Symptoms

The symptoms of this disease vary greatly. Briefly there may be cough, sputum, hemoptysis, dyspnea or pain. The latter symptom may be early but is usually late. Occasionally there may be no symptoms of the primary tumor whatsoever with the first evidence of malignancy being metastatic spread in the brain, bone, etc. The latter situation may occur with a very small tumor in the lung which may be almost impossible to locate by present diagnostic methods. The symptoms depend, for the most part, on the site and the size of the tumor. These tumors are diagnosed usually by one or several of the following methods:

1. Radiological examinations of various types.
2. Examination of the sputum for cancer cells.
3. Bronchoscopic examination with biopsy.
4. Thorocotomy.

These tumors have a very poor prognosis for the following reasons:

1. They often produce symptoms very late.
2. They invade surrounding vital organs.
3. They spread early by blood and lymphatics.

Today the average life expectancy of a person presenting himself with cancer of the lung is about three months. The length of time between the onset of symptoms and a fatal issue is about 12 months.

Treatment

The only adequate treatment of bronchogenic carcinoma is pneumonectomy with a complete removal of all mediastinal lymph nodes. Only 35% of patients when first seen are operable and in only 30% of these is the lesion confined to the lung. The five-year survival for all cases resected, in the published report of a large series, was 19% and with those who had lesions confined to the lung 38%. The five-year survival for all cases is approximately 5 to 6%.

Radiation treatment has been used for a number of years in the treatment of carcinoma of the lung but for the

most part this has been only of a palliative nature. However, in the recent years high voltage x-ray machines and cobalt therapy machines have made it possible to give higher doses to these lesions. It is possible that, as the techniques are improved, some cures will result. Certainly it is known that radiation treatment does decrease the size of the tumor in most instances. The irritating cough and the hemoptysis decrease and the patient has an improved feeling of well-being. However, as these cases are usually so far advanced when this method of treatment is used it is only to be considered a palliative method at the present time.

The British Columbia Cancer Institute

DOROTHY M. FINDLEY

HISTORICAL

THE BRITISH COLUMBIA Cancer Institute was established in 1938 by an anonymous donation of $50,000 to the British Columbia Cancer Foundation to be used in setting up a centre for the diagnosis and treatment of cancer. This gift enabled the Foundation to have processed one gram of radium, which had been purchased in 1936; to convert the former interns' residence of the Vancouver General Hospital into an Out-Patient Clinic; and to procure the services of a qualified radiotherapist, a radium technician, and a secretary.

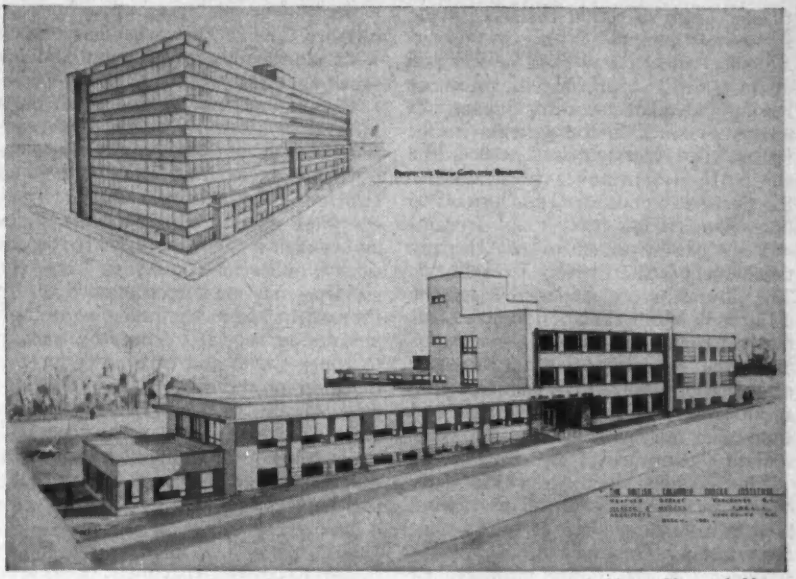
The war years intervened and there was no expansion. The number of new patients referred to the Institute, however, continued to increase. It was not until 1945 that further expansion was undertaken. The first x-ray machine was installed and put into operation. This machine, a 400 K.V. unit, was provided by the provincial government. In that year, the departments of x-ray therapy and social services were set up and the medical records department was enlarged.

During 1946 and 1947, the British Columbia Division of the Canadian Cancer Society began to work in close cooperation with the Cancer Foundation. The headquarters of the Cancer Society was established at the Institute. Joint campaigns for funds were held during these years and a portion allocated to the Foundation. Some $400,000 were set aside for expansion purposes.

In 1947 the need of the Institute for increased space and facilities became so pressing that a temporary building was erected with more x-ray therapy machines and a diagnostic x-ray unit. The province-wide responsibilities of the Foundation were now given consideration. In January, 1948, the Victoria Diagnostic Cancer Clinic was established at Royal Jubilee Hospital. This clinic was expanded to include treatments in 1951.

By the end of 1948, Consultative Cancer Clinics were opened at Penticton, Kelowna, Vernon and Kamloops. By July, 1950, clinics had been established at Nelson, Trail and Cranbrook. During the next two years clinics were added at Prince George and Prince Rupert. The purpose of this service is to assist in the diagnosis of cancer, to make recommendations regarding the treatment of patients referred by the medical profession in the areas concerned, and to carry out follow-up examinations on patients treated previously at the British Columbia Cancer Institute. A radiologist from the permanent staff of the Cancer Institute visits each consultative clinic at definite intervals.

Miss Findley is director of nurses at the Institute.



Architects, Mercer & Mercer

The British Columbia Cancer Institute, Vancouver

While the operating costs of the Institute are met by the federal-provincial grants in aid, capital costs are the responsibility of the British Columbia Cancer Foundation. The Foundation depends for funds upon public and private donations. Many generous bequests have been made to the Foundation since 1935. Donations have been received each year from the B.C. Division of the Canadian Cancer Society.

The Institute Today

In October, 1952, the new building of the British Columbia Cancer Institute was formally opened. It houses an enlarged business administration department, social service, radiotherapy, diagnostic x-ray, physics laboratory, and photographic department, a well equipped machine shop, doctors' offices, conference room and library.

The out-patient department has eight examining rooms, plus a minor surgery and sterilizing bay, dressing rooms and doctors' offices. This department is divided into two sections — one to examine new patients sent to the clinic and the other to see all follow-up cases.

The radiotherapy department has five x-ray machines ranging from 120 K.V. to 400 K.V. and a Cobalt 60 Beam therapy unit. The latter is housed in a room built especially for it. Designed and built in Canada, the cobalt was irradiated in the atomic pile at Chalk River. It is a beautiful piece of equipment and the Institute is justly proud to be the third possessor in the world of such a unit.

The Institute owns one gram of radium converted into 243 tubes and needles. The administration is by radium implant, surface radium plaques, and intracavitary application. The radium is housed on the top floor of the old building, the whole of this floor being devoted to this part of the radiotherapy department. There is a radium storeroom, workroom for radium preparation, a treatment room, and a large, modernly equipped mould room where moulds and plaques for radium therapy are designed and made. Here, too,

plaster beam direction casts are made for x-ray therapy.

Those who have worked in cramped quarters will appreciate the joy of having adequate working space. It means so much to the patients not to be crowded together and herded like sheep. It also means a great deal to the doctors, technicians, and nurses to have elbow room.

Very closely allied to the therapy department is the Physics Department. The physicists are responsible for the calibration of all radiation sources, for the provision of tables and graphs necessary for estimation of the dose of radiation received by patients, the specification of lead shielding, and equipment for measurement of stray radiation exposure of the staff.

The machine shop in which many of the accessories required in radium therapy are made is part of the Physics Department. This machine shop was equipped by the Grand Chapter of British Columbia Order of the Eastern Star.

The laboratory, now on the ground floor of the old building, is for hematology and cytology. Here frequent staff blood counts are done; routine cytology smears are taken on all pelvic cases, regardless of whether or not there is a positive biopsy report. Cytology smears are also taken on lung, bladder, mouth and breast cases, and from other parts of the body where it might help to establish a diagnosis. Diagnosis, however, never rests on the smear alone. Biopsy confirmation is essential.

The photographic department plays an increasing role of usefulness to the clinic. Before and after treatment, pictures are taken of all visible lesions, lumps, scar and therapy reactions, and skin graft procedures.

Social Service

Every person coming to the Cancer Institute as a new patient must first be seen by the Social Service Department, a member of which interviews the patient to assess his or her financial status so that the cost of treatment will not be a financial embarrassment to the needy patient. It is there the patient gets his original admission number. The social worker has contact with the various government and lay social agencies.

Patients are only accepted through referral of a family doctor. If the patient is from outside the city, the doctor is contacted, asking him to send relevant data, history of the case, operation reports, biopsy reports, slides and x-rays if there are any. If the patient is a Social Assistance Case, the social agency must be contacted before the patient leaves the municipality and permission received from the agency to cover travel and care costs for the duration of the stay in the city. Receipt of this information before the patient arrives for an appointment saves much time and difficulty to the Social Service Department and the patient.

Records

The Records Department of a clinic of this type is, of necessity, a large one. Complete records are kept wherein everything done for the patient is noted. It is on these records that clinical research is done. They must be handled with care and be well bound to stand frequent usage over the years. The statistical department is part of the Records Department. All the relevant data from the patient's medical record is put on cards that are filed and cross-indexed under anatomical site and histological diagnosis.

Boarding Home

Attached to the Institute is a boarding home of 14 beds. It is staffed by graduate nurses 24 hours a day plus some nurses' aides. This boarding home is for patients undergoing treatment or investigation.

Staff

The Institute has a permanent medical staff under the direction of A. M. Evans, M.D., C.M., D.M.R.E. The staff includes registered nurses, registered radiological technicians (the latter are all registered nurses also), social workers, business administration and office personnel, records librarian, statisticians, housekeepers, orderlies.

There is an attending medical staff of 90 specialists in all fields of medicine. This attending staff has a conference in the Institute once a week at which new patients are examined and their cases discussed and old patients are re-assessed. Clinics are held weekly at the Institute. There is an Ear, Nose and Throat Clinic, a Pain Clinic which is a research problem, a Lymphoma Clinic, as well as the daily therapy conference. This conference is attended by the permanent medical staff, radiological technicians, head clinic nurse, social workers, and physicians.

Research

The B.C. Cancer Institute is cooperating with the Therapeutic Trials Committee of the American Medical Association in a clinical research problem on the use of hormones in advanced carcinoma of the breast, now a standard treatment. There is also a long-term breast research problem being undertaken.

Auxiliary Services

Women's Auxiliary—provides and distributes magazines to all waiting rooms of the Institute; gives Christmas hampers for the patients; has an active sewing committee which mends all linen and makes various necessary articles.

Grand Chapter of B.C. Order of the Eastern Star—A room was allocated to the Order where members meet to make and distribute thousands of free dressings annually.

B.C. Division of the Canadian Cancer Society—This is a lay organization for the education of the public and for the promotion of research. The society conducts an annual drive for funds to help patients who are not on social assistance.

Imperial Order Daughters of the Empire—This Order has furnished and equipped a large room with a coffee bar, staffed by their members for the use of patients and their friends.

Audio-Visual Aids

Ruth Sleeper

The term audio-visual aid as used in this report, and in general in education today, designates all types of devices used as a means to improve teaching and to increase understanding. Nursing education is particularly fortunate in having at its disposal opportunities through which its students may have actual, direct, purposeful experience in nursing. These are, of course, the best possible audio-visual aids that any teacher can have to use. At times such aids either are not available or the particular material to be illustrated could not be appropriately shown in the practical situation. The teacher of nursing, therefore, like the teacher in other schools must look to the more artificial type of situation which she may use. The teacher may wish to use audio-visual aids that do not attempt to reproduce a nursing situation, as do demonstrations to a group or an individual student, showing how to do a nursing procedure; how to dissect a specimen; how to teach a mothers' class; or field trips and excursions.

The audio-visual aids recently introduced into schools, such as films, radio, recordings, and still pictures, have brought an infinite variety of new opportunities to enrich the teaching and make it more meaningful. Moving pictures, either silent or sound, radio

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broadcasts which describe such developments as the World Health Organization or community programs; recordings made by schools to preserve lectures of special importance; still pictures, such as slides of bacteria, slides showing poor and good examples of housing, or lectures illustrated by books and pictures through the use of the epidiascope—all of these are among the audio-visual aids which may be used in the school of nursing today. Because I have left them until last does not mean that I would depreciate in any way the older type of audio-visual aid, such as charts, maps, graphs, posters, bulletin board and blackboard illustrations. All of these have a great value and, used appropriately, are equivalent to the new types of audio-visual aid.

Values

What values have the audio-visual aids in schools of nursing? Effective learning is said to take place:

1. When the student is properly motivated—that is, when she knows *why* she should learn.
2. When the student recognizes the objective of her study or when she knows *what* she is expected to do as a result of her learning.
3. When she can put her learning into practice or when she can actually use what she has learned.

Such learning takes place when the study includes meaningful experiences which develop clear and thorough understandings, which teach interrelationships and build right attitudes toward the material to be learned and its future use. Audio-visual aids wisely selected and effectively used may increase student participation and so improve motivation. They may direct student attention to the desired learnings. They may stimulate student discussion. As students can handle or use the aids both in the classroom and for out-of-class review and study, the objectives of the study may be clarified and insight developed into the use of the material to be learned. Finally, because the aids may give deeper meaning to the teaching and learning, the use of audio-visual aids may contribute to the development of the desired attitudes.

Audio-visual aids do help to enrich both teaching and learning. They may also help to provide essential experiences not available to any or all of the students in the class. Some aids make possible a necessary emphasis on important details. Others are helpful because a subject can be presented in its entirety. They may help to assure common understanding between teacher and student. As they are more tangible than verbal descriptions, they will help some students to avoid misunderstandings. For some students the audio-visual aid brings the subject from the text or reference book to their own level of experience. Because she is able to see, hear, and feel the aids, several senses are involved and more rapid or more effective learning may thereby be stimulated.

Selection of Aids

What principles guide the selection of good audio-visual aids? A school planning a collection will wish to obtain the most useful aids at prices consistent with their usefulness, with the customs of the country, and with the needs in general of the school. It is important when aids are purchased to select those that will be (1) usable over a period of time; (2) useful in more than one course, if possible; (3) adapted to frequent use. The criteria used in selecting aids commonly include:

1. *Reliability:* Will the aid foster sound learning? Is it authentic? Is it accurate in detail? Is the information it will teach up to date?
2. *Suitability:* Will the aid be pertinent to the subject matter with which it will be used? Is it adapted to the students' level of learning? Does it provide necessary information or experience? Is it comprehensive enough to be meaningful? Will it appeal to the students' interests? What will be the frequency of its use?
3. *Clarity:* Is the aid simple and clear or is its effectiveness sacrificed to artistic effect? Is its meaning obscured by too many details? Does it include attention-getting devices? Are its objectives evident?

4. *Educational value:* Will the aid facilitate learning? Does it save student and teacher time? Will it increase the permanency of the learning? Will it provide essential experiences not otherwise available to the student? Does it contribute to the objectives of the lesson or course of study? Is it related to the needs of the student?

Effective Use

What principles may be used to guide the effective use of audio-visual aids? The audio-visual aid is *not a method of teaching.* It is a tool to be used to supplement and enrich all teaching methods. As the teacher consciously or out of habit considers good teaching principles when she plans a course or a lesson, so she considers these same principles as she chooses the appropriate audio-visual aids.

The teacher who uses these aids with best results is the one who selects them as she plans each lesson, indicating in her plan when the aid is to be used, how it will be used, and what learnings should result from its use. In her plan she will see that the learning needs of the individual students are considered; that the lesson, in part through these aids, provides for maximum activity for every student; that previous experiences are related to the new material to be learned; that the lesson makes possible a wide enough variety of experiences to be meaningful to every student; that the student will have opportunity to recognize and benefit by her mistakes; and that motivation for all will be provided.

What teaching techniques may be employed to assure learning when audio-visual aids are used? The teacher must be thoroughly familiar with the form to be used. Slides, films, and other types of aids should be reviewed carefully before use. To be most meaningful, the aid must be introduced at the appropriate time in the lesson. If its use has been preceded by a description, by a statement of the problem with which the aid is to assist, or by other pertinent discussion that will prevent misunderstandings, the student will tend to be more receptive to it.

Before a complicated or comprehensive aid is introduced, such as a film, record, or filmstrip, or before actual experience, or a demonstration, or excursion, the students should know what their responsibilities are when the aid is shown: (1) either what is the problem to be solved by its use, (2) or why the aid is used, (3) or how the aid will help.

Testing

Attention may be directed to essential learnings if, before the aid is displayed, students are warned that some type of testing will follow the use of the aid. This testing may be an actual examination, written or oral, a class discussion, or a written or verbal report. If the necessary information may be gained from a part of a film only, the teacher may refrain from showing the entire film or filmstrip. Unnecessary parts may only serve to distract attention from the essential values. During the showing of the aids students will usually gain if the instructor calls attention to the important points.

Immediately, or as soon as possible after a comprehensive aid has been used, students will benefit if given opportunity to apply their learnings. The manner in which this is done will be determined by the lesson. If students have not grasped the desired ideas, the teacher may then show parts of the film again or, when appropriate, send students to repeat part of an excursion to secure the necessary information.

Storing Aids

When several instructors are using the same audio-visual aids the value of the school's collection will be increased if one instructor or the school librarian can be made responsible for storing and dispensing the aids needed. A central card file, with comments from each instructor on the card, will increase the value of the collection. Each teacher, however, may wish her own card file of aids that she found especially adapted for use in each of her particular courses. It is vital that any collection of audio-visual aids be a growing one. Aids should be reviewed

frequently, old ones discarded and new ones added.

Making the Aids

What audio-visual aids may be prepared by teacher and student? Nursing education is uniquely fortunate in its opportunity to secure direct, purposeful experiences for its students at all stages of their learning. Actual patient care in the ward or clinic, the opportunity to follow the patient to x-ray, to the operating room, or to the metabolism room, etc., are all experiences rich with illustrations that teach directly as the student manages both patient and equipment in the actual situation. Although the teacher does not make these aids she does make the plan for the student's experience, supervises the student's activity, and prepares some means of evaluation for use at the appropriate time.

The teacher may, however, actually make her own audio-visual aids or guide students to make them. If the time required to make the aid is not out of proportion to its value, the preparation of some aids may be assigned to students as sound learning experiences.

Models and Specimens

Modelling clay or plasticine may be used to make models of body organs. Different colored clays are useful to emphasize different parts of the model or the essential ideas to be learned. Clay models to be used over a period of time may be mounted on a small board and covered with cellophane. Model of the mechanics of respiration—bell jar, two balloons, and rubber dome; model for orthopedic nursing—dolls in small beds arranged to show splints, traction, bed-making positioning. Specimens of organs from pathological laboratory in glass jar of formalin or other preservative—covered tightly to preserve between use—should be sealed with paraffin if never to be removed for handling. Dissection of organ may be done to show important parts. Organ may be tied to glass rods for support so that it may be studied more effectively and labelled to call attention to desired learning. Specimens from the butcher shop may be preserved if expensive or difficult to secure. Microscopic slides of bacteria from hospital laboratory or other sources stained and mounted for permanent use. Labels to indicate desired learnings.

Films

The making of moving pictures is an exacting work. It is wise to have the direction of experts in making the plan for the film. Local audio-visual aid dealers or photographers may give assistance.

Slides

The type of slide to be made will vary with the type of projector to be used. Photographic slides may be made by anyone who uses a camera. The pictures to be taken may include charts, maps, graphs, pictures of equipment, or people in action. The photographic negative may be printed on a glass slide by anyone who develops pictures. This slide is covered by another clear glass slide and the edges of the two slides are taped together. A black and white or colored photographic negative may be mounted directly for use on cardboard. Books on slide-making are available from manufacturers of photographic equipment.

Other types of slides may be made less expensively. The rough surface of etched glass, cut to proper size, may be used for applying ink or crayon to make the drawing. Colored inks or crayon make slides effective and attractive. Clear glass must be coated if best results are to be obtained. One side of the glass may be covered with ordinary dessert gelatin (¼ teaspoon to 1 cup of hot water; dip one side of glass into gelatin; allow to dry). Lacquer may be used (1 part clear lacquer to 50 to 100 parts of lacquer thinner). Beginners in the art of slide-making are advised to draw on paper and to trace the drawing onto the slide. Erasures may smudge and so spoil the slide. Coloring to be used must be transparent.

Charts, Maps, Graphs

These are easily adapted to home manufacture. Items cut from magazines are mounted on heavy paper or card-

board, labelled clearly in large letters. Drawings by students or teacher may be treated in the same manner. If all similar visual aids can be mounted on the same size paper or cardboard, the storage of all will be easier. A good chart or map is simple in detail. If much detail is needed the use of several, each of which gives a part only of the desired information, is to be preferred to one that is overcrowded and thus confusing.

Colors may be used effectively to symbolize certain data but, except when true, care must be taken to assure that the color in itself has no relationship to the data indicated. To assure satisfactory use in a class, charts or maps should be large enough to be clear at a distance. The most effective sizes are 22 by 28 inches or larger. Again it is important that students actually feel the differences in size of objects as they appear on the chart or map and as they exist in life.

The graph is most useful when the teacher wishes to show quantitative data. Such a graph has a clear and appropriate title to indicate what the student should find on reading it. The maker should not try to tell too much in one graph. Five types of graphs seem to be widely used: pictorial statistics; pie charts; area and solid diagrams; bar charts; line or curve graphs. Every teacher who can use graphs to good advantage should secure a simple book on graphing.

Bulletin Board Displays

These are important teaching aids. The bulletin board is well adapted for announcements, pictures, news cuttings, charts, maps, graphs, from any reliable source. Some of the factors that assure success in the use of this method include: Items displayed must be well labelled or the desired meaning will be missed. Color, spacing, and attractiveness of arrangement serve to call attention to the display. Frequency of change of items adds interest. Good lighting is vital. Bulletin boards should be located where students frequently pass.

Blackboard Illustrations

The blackboard is one of the most effective and least expensive of audio-visual aids. Illustrations may be provided by either teacher or student. They may be drawn during or before the class hour. Drawn during the class helps to visualize the desired idea, more than the finished illustration. The students' thinking tends to expand as the drawing takes form. The instructor's comments as she draws provide a most effective addition. The simple, brief diagram is most effective. Color gives emphasis to the essential parts. Unrelated material which is easily erased eliminates distraction. Like other aids, blackboard illustrations should be planned in advance. Complicated, time-consuming drawings should always be completed to the place where they can be finished during the class hour.

Sources of Aids

In compiling a list of the sources from which audio-visual aids may be obtained, several factors must be kept in mind. There are many problems associated with the purchase of teaching materials from different countries. Language differences may make good aids useless when students cannot read or understand the captions or the explanatory statements. Differences in nursing methods in countries may make what is a good audio-visual aid in one country an inadequate or useless teaching tool in another country.

A man is rich in proportion to the number of things he can afford to let alone.

— Thoreau

* * *

One is not rich by what one owns, but by what one is able to do without with dignity.

— Kant

This earth is no resting place . . . This earth is no playing place . . . We fight not for ourselves, but for growth — growth that goes on forever. Tomorrow, whether we live or die, growth will conquer through us. That is the law of the spirit for evermore.

— H. G. Wells

All Aboard for Banff!

FROM MONTREAL BY SPECIAL TRAIN VIA CANADIAN PACIFIC RAILWAY

Thu. June 3	Lv. Montreal	7:15 p.m.
	Lv. Ottawa	9:45 p.m.
Fri. June 4	Lv. North Bay	4:30 a.m.
	Lv. Sudbury	8:20 a.m.
	Lv. Fort William	11:45 p.m.
Sat. June 5	Lv. Winnipeg	11:15 a.m.
	Lv. Brandon	2:30 p.m.
	Lv. Regina	7:35 p.m.
	Lv. Moose Jaw	9:05 p.m.
	Lv. Swift Current	11:55 p.m.
Sun. June 6	Lv. Medicine Hat	4:00 a.m.
	Lv. Calgary	9:25 a.m.
	Ar. Banff	11:35 a.m.

FROM TORONTO BY SPECIAL TRAIN VIA CANADIAN PACIFIC RAILWAY

Thu. June 3	Lv. Toronto	11:00 p.m.
Fri. June 4	Lv. Sudbury	7:20 a.m.
	Lv. Fort William	10:40 p.m.
Sat. June 5	Lv. Winnipeg	10:05 a.m.
	Lv. Brandon	1:15 p.m.
	Lv. Regina	6:25 p.m.
	Lv. Moose Jaw	7:55 p.m.
	Lv. Swift Current	10:45 p.m.
Sun. June 6	Lv. Medicine Hat	2:50 a.m.
	Lv. Calgary	8:20 a.m.
	Ar. Banff	10:45 a.m.

FROM VICTORIA & NANAIMO BY CANADIAN PACIFIC STEAMER. FROM VANCOUVER BY SPECIAL TRAIN VIA CANADIAN PACIFIC RAILWAY

Sat. June 5	Lv. Victoria	1:10 p.m.
	Ar. Vancouver	5:25 p.m.
	Lv. Nanaimo	2:00 p.m.
	Ar. Vancouver	4:15 p.m.
	Lv. Vancouver	7:30 p.m.
	Lv. Mission	8:45 p.m.
	Lv. Agassiz	9:25 p.m.
Sun. June 6	Lv. Kamloops	4:10 a.m.
	Lv. Revelstoke	8:55 a.m.
	Lv. Field	3:25 p.m.
	Ar. Banff	5:05 p.m.

YOUR NEAREST CANADIAN PACIFIC Agent will gladly quote rates from other points, also rates for other types of sleeping-car accommodation, give any additional information required, and arrange reservations covering your entire trip; with the exception of hotel reservations at Banff which must be made through the Housing Committee. He will also be glad to issue all tickets covering the round trip, prior to your departure.

There are a number of optional return routes available. For those from the Pacific Coast, also those from the East who will include the Pacific Coast in their itinerary, the Kettle Valley and spectacular Coquihalla Canyon route is highly recommended on the homeward trip. Those from east of the Great Lakes will enjoy the delightful interlude of a restful trip across the Great Lakes from Fort William Tuesdays and Saturdays to Port McNicoll where direct train connection is made for Toronto and other eastern destinations.

Ask your agent for full particulars of routes available.

CONVENTION RAIL FARES WITH LOWER FIRST-CLASS BERTH AND LOWER TOURIST BERTH TO BANFF AND RETURN

From	*With Lower First-Class Berth*	*With Lower Tourist Berth*
St. John's, Nfld.	$300.75	*$262.45
Halifax	236.15	* 197.80
Charlottetown	231.25	* 192.95
Saint John, N.B.	214.40	* 176.10
Montreal	174.80	136.50
Ottawa	165.55	128.95
Toronto	154.90	117.20
Fort William	102.05	84.50
Winnipeg	69.35	57.45
Brandon	62.15	51.50
Regina	44.40	36.90
†Victoria	49.50	42.00
†Nanaimo	46.85	39.35
Vancouver	43.85	36.35

*Fares include lower first-class berth east of Montreal.

†Fares from Victoria and Nanaimo include lower berth Vancouver to Banff and return only.

Fares and Times shown are subject to change.

Get all Reservations in Early!

Pacific Coast

Five days as outlined in the August issue. Reservations and tickets covering this trip should be arranged through your local Canadian Pacific Agent.

Alaska

Up to the present, sailing dates from Vancouver to Skagway and return for the summer of 1954 have not been decided but it is expected the Canadian Pacific will have the *S.S. Princess Louise* and the Canadian National will have the *T.S.S. Prince George* in this service. In addition the Canadian Pacific Airlines have a service, daily except Sunday, between Vancouver and Whitehorse, making it possible for those who so desire to fly one way.

Round trip by steamer costs $165.66, including meals and minimum priced first-class berth, plus approximately $10.00 if passenger remains on board at Skagway. Vancouver to Whitehorse and return by air is $158. By steamer Vancouver to Skagway, including meals and minimum priced first-class berth, rail from Skagway to Whitehorse, and air from Whitehorse to Vancouver, is $177.08, or this can be done in reverse. Those interested in the Alaskan trip, please fill in and forward the tear sheet to me promptly. I will forward full information as soon as the sailing dates are announced.

Hawaiian-Pacific Paradise

We regret that an error was made in the number of days shown in the August issue. This tour actually covers ten days, as follows:

Sun. June 13. Leave Vancouver on a luxurious Canadian Pacific Empress Airliner, arriving Honolulu that evening; transfer by limousine to the Moana Hotel.

Mon. June 14. At Waikiki.

Tue. June 15. Circle tour of island.

Wed. June 16. At Waikiki.

Thu. June 17. Mt. Tantalus tour.

Fri. June 18. & Sat. June 19. At Waikiki.

Sun. June 20. Koko Crater tour.

Mon. June 21 & Tue. June 22. At Waikiki.

Wed. June 23. In the morning transfer by limousine to the airport, leave on a Canadian Pacific Empress Airliner, arriving Vancouver at 8:15 p.m. Cost from Vancouver to Honolulu and re-

C.P.R. Photo

Mountain goats grazing at foot of Columbia Icefields

turn, including air fare, taxis to and from airport in Vancouver and Honolulu, hotel accommodation (two to a room with bath) and 3 sightseeing trips — $380.25 each. First-class rail fare and lower first-class berth Banff to Vancouver and return — $50.30. Those interested in this tour should complete the tear sheet requesting reservations and forward it promptly.

It is possible that those from the East who will be going to the Pacific Coast may find it less expensive to purchase a regular ticket to the Coast and return, rather than a convention ticket to Banff and return, plus a regular ticket from Banff to the Pacific Coast and return. Consult your local agent regarding this.

— ETHEL ARMSTRONG COLLINS

ALASKA POST-CONVENTION TRIP

Ethel Armstrong Collins
Chairman of Transportation
134 Bloor Street, West
Toronto 5, Ontario

Date .....

I am interested in a post-convention trip to Alaska, travelling (indicate by X):

( ) Round trip by steamer
( ) One way by air and one way by steamer
( ) Round trip by air

and would like to leave Vancouver approximately.....
date

and return to Vancouver.....

Signed.....

Address .....

.....

HAWAIIAN—PACIFIC PARADISE POST-CONVENTION TOUR

Ethel Armstrong Collins
Chairman of Transportation
134 Bloor Street, West
Toronto 5, Ontario

Date .....

Enclosed please find money order payable to you in the amount of fifty dollars ($50.00) to cover deposit on the above tour.

I will share a twin-bedded room with bath with.....

.....

whose address is.....

.....

Signed.....

Address.....

.....

PRE-REGISTER FOR THE 27TH BIENNIAL MEETING

THE CANADIAN NURSES' ASSOCIATION
BANFF SPRINGS HOTEL, BANFF, ALBERTA
JUNE 7-11, 1954

Name .....

Address .....

.....

Position .....

Organization or Hospital .....

Province in which registered .....

Current Registration Number .....

If Associate Member, state Province .....

When you have completed this form, please:

1. Send it to the
   Canadian Nurses' Association
   Suite 401, 1411 Crescent Street
   Montreal 25, Quebec
2. Enclose a money order or cheque (plus exchange if outside Montreal, please) for five dollars ($5.00).

You will then receive:

1. A receipt for your registration fee.
2. Your registration card which will entitle you to receive your badge, typed in advance, the program and other material, at Banff.
3. A Housing Reservation Card that you may complete and send to the Chairman of the Housing Committee.
4. Information concerning accommodation available at Banff and a copy of the Alberta "Holiday Guide."

STUDENT NURSES

1. Name .....

2. Name of School of Nursing .....

3. Address .....

Students — please complete this form and send to National Office with the student registration fee of two dollars ($2.00).

INSCRIPTION ANTÉRIEURE AU 27e CONGRÈS BIENNAL

L'ASSOCIATION DES INFIRMIÈRES CANADIENNES
BANFF SPRINGS HOTEL, BANFF, ALBERTA
JUIN 7-11, 1954

Nom .....

Adresse .....

.....

Emploi .....

Organisation ou Hôpital .....

Province dans laquelle vous êtes enregistrée .....

No. d'enregistrement annuel .....

Les membres associés, s.v.p. indiquez province .....

Lorsque vous aurez complété cette formule, bien vouloir:

1. L'envoyer à
   L'Association des Infirmières Canadiennes
   ch. 401, 1411 rue Crescent
   Montréal 25, Québec
2. Inclure un chèque ou un mandat-poste de cinq dollars ($5.00) (plus les frais d'encaissement, si vous habitez en dehors de Montréal).

Vous recevrez alors:

1. Un reçu de votre droit d'inscription.
2. Votre carte d'inscription, laquelle vous donne droit à une insigne portant votre nom imprimé à l'avance, le programme et autres choses qui vous seront remises à Banff.
3. Une carte de réservation de logement, que vous retournerez à la convocatrice du Comité du Logement, après l'avoir complétée.
4. Un feuillet "Holiday Guide" vous donnant la liste des hôtels et pensions à Banff et en Alberta.

ÉTUDIANTES-INFIRMIÈRES

1. Nom .....

2. Nom de l'école .....

3. Adresse .....

Etudiantes — veuillez compléter cette formule et l'adresser au Secrétariat National avec le montant de l'inscription pour étudiantes, deux dollars ($2.00).

Institutional Nursing

Our Concepts of a Psychiatric Nursing Affiliation

MURIEL A. DOUCETT

EDUCATIONALISTS IN THE FIELD of nursing are becoming increasingly aware of the evident need of psychiatric nursing affiliations but a great many are still unable to arrange such an affiliation for all of their students. General hospitals that have difficulty with ward service when too many students are away on affiliation may not be able to send more at the present time, nor are there an adequate number of affiliating centres to provide such an affiliation for all students in training. What comprises such an affiliation?

To outline a curriculum for a 12-week period that will give the student nurse a working knowledge of psychiatric nursing requires careful thought, flexible planning, and close cooperation from the lecturers participating in the program. Our students arrive from seven schools of nursing in the province, bringing with them a variety of experiences, acquired knowledge and skills, and a still wider variety of attitudes and preconceived ideas. Probably the most common of the latter is that mental illness is unpreventable and incurable. Their idea that custodial care is all that there is to offer a mentally ill person is rather revealing. The students expect to be taught how to care for the frankly psychotic patient but at the same time are unaware of the emotional needs of the vast numbers of disturbed patients who are in general hospitals. Nor are they concerned with the fact that good mental hygiene, if stressed, would have kept some of our patients well and that the early recognition of symptoms and treatment would have shortened if not eliminated hospital care.

The orientation program covers the first two days and gives the student ample time to tag names to faces, find her way around the hospital grounds, acquaint herself with her new home (the residence) and, most important of all, to find her place as a member of the affiliating class, not as a student from a certain school. The welcome, outline of the course, tour of the hospital, policies of the school, routine tuberculins, chest x-rays, and individual personal interviews are carefully included in the schedule to allow the student ample time for good adjustment. We feel these first two days are the foundation for the blocks of knowledge the student will build in the next 12 weeks. As we start out on the course the faculty share several definite objectives which might be stated as:

1. To give the student a better understanding of herself — her own feelings, reactions, and emotions, difficulties, abilities and limitations, and by so doing assist her to make satisfactory adjustments.

2. To teach the relationship of physical and mental illnesses and to recognize that the art of nursing is the art of skillfully caring for the entire person — mentally, physically, and socially.

3. To give the student an understanding of mental illness, prevention, etiology, symptoms, treatment, and principles of psychiatric nursing.

4. To teach the rules of mental hygiene so that the nurse may be guided in giving health teaching to her patients to assist them in community readjustment. Indirectly this would enable the nurse to make a valuable contribution

Miss Doucett is director of nursing education at the Ontario Hospital, New Toronto.

to healthful living in the community.

By the third day we hope the student has begun to feel at home and is looking forward keenly to her new work. We spend the greater part of this day in the classroom having classes and the remainder on the wards. By doing this we can provide the student with the theory of the nursing care routine of the insulin coma and electroshock patients (with whom they come in contact as soon as they arrive on the wards) and also allow ample time for thorough ward orientation.

The practical experience received by the student takes place on the male and female admission wards, female insulin ward, and on a female convalescent ward. By rotating through these wards at three-week intervals it is possible to see the patients in varying degrees of illness and stages of treatment. In most instances the nursing of the insulin coma patients and those receiving electroshock, though entirely new procedures, gives little difficulty. The hospital routines, including attendance at the clinics (eye, E.N.T. and surgical), the active treatment of the patient, psychotherapy, progress made by the patient, as well as medical conferences (where each case is discussed for diagnosis, treatment or trial visit at home) are all included at various stages of their ward experience. Occupational therapy experience received on the ward and in the studio provides the student with a valuable tool for her psychiatric nursing kit. The visits made by the students to social agencies and rehabilitation centres provide authentic information regarding the follow-up care needed for handicapped persons, since we feel the responsibility the community has toward helping such persons cannot be overemphasized.

The student works an eight-hour day including classes, which average two hours daily. Two of her 12 weeks she will work broken time, thus getting a better knowledge of the evening care required and nursing problems that arise. The off-duty time in her 44-hour week is free of lectures. This is arranged to allow ample time for rest, recreation, assignments and study. A weekly morning off enables the student to have extra rest and every second week-end off duty enables her to carry on social contacts. Thus we feel her weekly day and a half off duty is most satisfactorily arranged from all angles.

We are very conscious of the fact that time plays a large part in this 12-week learning period. The ward teaching, clinical teaching, and assignments are planned to enable the student to apply her theory as she progresses. For this reason the latter part of the course seems more concentrated since the student must first adjust, then master her theory before making much progress. Several other factors color her progress. Hindered by the fact she may have had little or no special training (e.g., obstetrics, surgery, etc.) she will, of course, have more difficulty in her adjustment to ward work, as well as to her patient, than if she were a senior student.

Perhaps the most difficult part of the affiliation for some is this problem of adjustment. Having no knowledge of mentally ill patients — no idea of treatment — the fear of the "unknown" is overwhelming. The student who asked us during her orientation period how many padded cells there are in the hospital gave us a peep into most students' expectations. Many are in the same situation, for in comparing first impressions of the students they really are not certain what to expect when they come to us. We are hopeful this will disappear in time, when more is known about mental illness and when all students have an opportunity to receive a psychiatric affiliation.

The personal development of the student is also given careful attention. We have tried to give her the opportunity to function as a part of a student government, sharing responsibility for class progress. The success of this is still unknown for many come from schools where there is no student government or from schools that have a government that functions in a different manner. To combine the efforts of students from such schools into an organized group is very interesting though difficult, for the molding of

attitudes cannot be done overnight.

In each class each school has a representative. From among these the students choose a chairman, vice-chairman, secretary-treasurer, and social convener. The entire student body is encouraged to live as a family, to work toward a common goal — self-development, self-discipline, and self-responsibility. Additional privileges are granted as the students prove their ability to shoulder added responsibility. The investment of time, leadership, and direction is well repaid in the interest, enthusiasm, effort and efficiency which result.

By the time the student is ready to return to her home school we feel her psychiatric affiliation should be helpful in several ways. Not only should she be better equipped to give more understanding nursing care by putting into practice her new-found knowledge but she should also be able to recognize early deviations from normal living as well as the guideposts along the road to successful personal living. As a result of this affiliation her contribution as a health worker in the various phases of everyday living should be more valuable, lasting and satisfying.

To gain the full value of the course the student must feel her interest and progress is of prime importance to the entire staff and that she is a part of the psychiatric team. When the course is completed and good-byes are being said there should be a mutual feeling of satisfaction between the hospital staff and the affiliating class in the assurance of having given much and received much.

In the Good Old Days

(*The Canadian Nurse* — October 1913)

"The policy of the Canadian National Association of Nurses is the union or affiliation of all Canadian nursing associations so that every nurse may have a voice in nursing education and interests and, incidentally, in the betterment of nursing conditions throughout the Dominion."

* * *

"It is now six years since Dr. J. B. Murphy of Chicago worked out his system of administering large quantities of saline solution per rectum, a method of treatment which has saved many lives... The skill of the nurse in administering it is an all-important factor in the results obtained."

* * *

"For thirst following surgical operations it will be well to remember Semmola's glycerine drink which is often exceedingly gratifying. It is one ounce of glycerine and 30 grains of citric acid to a pint of water."

* * *

"The secret of taking unpleasant medicines without tasting them lies almost entirely in removing all traces of the drug from the mouth before drawing a breath after swallowing it. For cleansing the mouth after caster oil or other oils, probably nothing is better than chewing up and spitting out a liberal quantity of bread. Do not, however, as one nurse did, bring bread spread with butter to the patient!"

Today is not yesterday. We ourselves change. How can our works and thoughts, if they are always to be the fittest, continue always the same? Change, indeed, is painful, yet ever needful; and if memory has its force and worth, so also has hope.

— Thomas Carlyle

He who is of a calm and happy nature will hardly feel the pressure of age.

—Plato

The only conquests which are permanent, and leave no regrets, are our conquests over ourselves.

— Napoleon Bonaparte

Public Health Nursing

Nurse Among the Oil Wells

HUGH G. JARMAN

THE TALL, ATTRACTIVE young woman, dressed in ski togs and carrying a little black bag, came striding across the drill site to the complete astonishment of the toolpushers, drillers, cathead men and other members of the drilling crew.

Their surprise was understandable. This was a wildcat well in a distant corner of Alberta, a man's domain. For several days the temperature had ranged from 25 to 45° below zero. Around the drill site was a mass of snow, frozen mud and muskeg. Not long before, the bulldozed road leading in to the site had been blocked. But here was the young woman, trim, calm and businesslike, just as if she were walking into an office building in Edmonton.

The astonishment was short-lived. The toolpusher (head man at the rig) announced that the unusual visitor was "the company nurse," arrived to check on health conditions at the drilling centre. In her little black bag were syringes, needles, vaccines, toxoids, sterile towels, bandages and dressings as the instruments of preventive medicine. She unpacked her bag and quickly began her duties as a guardian of health in remote areas.

All photos courtesy Imperial Oil Ltd.

A mechanic gets a TABT shot

All of this happened a couple of winters ago. Since then, the company nurse has become a familiar figure in oil communities of northern Alberta. Wildcatters in remote areas, and the families of the oil men in less distant camps, are no longer surprised when they see the nurse arrive by caterpillar tractor, truck, car or stepping out of the caboose of a freight train. Now when they see her, the word goes round: "Here comes the company nurse with her little bag of tricks."

Hundreds of oil workers, their wives and a host of youngsters, living in portable cabins or "skidhouses" that follow the oil rigs from site to site, have come to know the nurse. They welcome her for the free inoculations in areas where the water and milk supplies are of doubtful purity, for advice on child care, for her practical attention to any kind of injury, and for the good cheer she brings.

The work is a part of the program of preventive medicine conducted by the Imperial Oil Company's medical department which has headquarters in Toronto. With the expansion of Imperial's activities in Alberta, it was decided to set up a branch office in Edmonton. A doctor and a nurse were appointed to undertake the work there. Since the program was introduced at Edmonton in 1949, some 2,400 inoculations and vaccinations have been given to oil workers and members of their families at their request. Thousands of pieces of health literature have been mailed out and bulging office files testify to the mass of personal correspondence.

Their job was not a simple one. As physician-at-large and nurse-secretary operating out of Edmonton, they had to blaze their own trails of health

education. Except for the medical examination on first employment, all participation by employees in Imperial's health program is on a purely voluntary basis. The employee can accept or reject periodic health check-ups, inoculations or other features of the program at his own discretion. The first trips were, in a sense, missions for "selling medicine"—to explain to each employee, individually, the purpose of the program and what is offered.

The doctor gave a series of talks in all departments of Imperial's operations in Alberta. He explained the need for inoculations against typhoid, tetanus, diphtheria, whooping cough and smallpox, and outlined the purpose of periodic health examinations and consultations. He emphasized that the medical records of each individual are completely confidential, entirely a matter between the company doctor and the employee or the employee's family doctor.

In January, this medical team journeyed to the Peace River country 350 miles north of Edmonton. That was their first close look at the oil rigs in action and at the portable cabin camps where the oil workers' families live.

These one- and two-room homes, mounted on skids or runners, are winched up on trucks or loaded on railway flat cars, when being moved from one location to another. Unloaded in fields at the end of settlements, hamlets or villages, they are placed to face each other across a square. They form a temporary oil community for 20 or 30 families while drilling is in progress nearby.

On the first trip to McLennan, in the Peace River, temperatures hovered at 25° below and roads were rough and slippery with ice. The medical team launched their program in a partially completed boilerhouse where the men gathered around the stove for warmth. They visited two rigs on an 820-mile trip from Edmonton by car, and gave talks, immunized 23 persons for typhoid, visited babies in the cabin camps, and checked water supplies.

That set the pioneer medical program in motion and in March, April and May of that winter—one of the coldest experienced on the prairies—the nurse travelled on her own. To inoculate the crew at a camp near McLennan, she had to work around the clock, catching the men as they came off shift at 8:00 a.m., 4:00 p.m. and midnight. Her clinic was a vacated cabin. In addition to the men, the nurse inoculated many wives and children, working first at the rig itself, then travelling by truck over a rough bulldozed road to the cabin camp. She checked on the sanitation at the camp, found it in good order, and visited two expectant mothers.

Employees' families get care too

There was a drastic change in the travelling conditions on her next trip. The freezing, snowbound journeys gave place to the soggy April thaw when the rich soil of the Peace River area became a gumbo, a glue-like lake

Safe water supplies are important

of mud. It took her two and a half hours to travel the eight miles from the campsite to the rig, riding a power truck with a tractor to help over sections of the road that were almost impassable.

At McLennan she had set up a small clinic for infants and preschool children. One of her duties was to acquaint young mothers with the local facilities for child care which are provided by the provincial Department of Public Health through district nurses stationed at various centres.

The families were happy and well adjusted. Of course there was always some wonder about where the next move would take them. The mothers were extremely interested in the nurse's work and there were many opportunities for general health talks.

These trips are typical of the work done in the field. Almost always there is some incident to remember—such as the family of nine children whom she lined up for inoculation, starting from the tallest down to the tiniest.

When she returns to Edmonton, the nurse always finds a good deal of work to be handled. The seven-room medical office is the centre for continuous health counselling following pre-placement and periodic medical examinations. This is carried on both directly with the employee and by personal correspondence.

Rehabilitation in Nursing

A generous grant of $7,500 from the Atkinson Charitable Foundation plus assistance from the National funds of the Order will mean that V.O.N. nurses all over Canada will be able to master the latest techniques of modern rehabilitation nursing under expert guidance.

Conferences have been planned "to provide our nurses with a better understanding of the newer methods of nursing care that incorporate the principles of physical restoration and rehabilitation of patients with every type of illness."

The instructor is Miss Helen Anderson, Assistant Professor, University of Washington School of Nursing, Seattle, who is exceptionally well qualified for the task. Miss Esther Robertson, educational supervisor with the V.O.N., is collaborating.

Eight major centres in Canada have been chosen for the conferences — Ottawa, Toronto, Hamilton, Windsor, Saint John, Halifax, Winnipeg, and Vancouver. Each conference takes two and a half days and in the larger centres is being repeated for different groups of about 20 nurses each.

The conferences are of necessity only available to nurses on the V.O.N. staffs. An exception is being made. The nursing arts instructor of the hospital where the conferences are held is invited to observe.

This should prove a most stimulating and interesting project and cannot help but attain its ultimate objective — better nursing care.

Geniuses don't die young, as a rule. Famous cases of brilliant lights snuffed out by early death, like those of Shelley, Keats, Schiller, Heine and Raphael, are exceptions, accounting for only one-half of one per cent of the world's acknowledged geniuses, declares Dr. R. E. G. Armattoe, director of the Lomeshie Research Centre for Anthropology and Race Biology in Londonderry, Ireland.

Offsetting the early deaths of these young geniuses are the long lives of many other noted men, he points out. Classic instances are Michelangelo, Da Vinci, Corneille, Goethe and Newton; among the great who have died more recently at advanced ages were H. G. Wells, Shaw, and Max Planck. Still living, full of years and honors, are Sibelius and Einstein.

In certain other traits, however, Dr. Armattoe found geniuses to conform more closely to popular beliefs concerning them. Among these are a high degree of self-esteem, an infinite capacity for taking pains, and an indifference to the accepted code of sex morals. — *Science News Letter*

Trends in Nursing

27th Biennial Meeting

ALTHOUGH WE ARE all receiving information about our convention and Banff in every issue of *The Canadian Nurse,* perhaps now is the time to draw the threads together again so that we may have a broad look at how things stand at the present.

One development has been the appointment of a Sub-Committee on Housing of the Committee on Arrangements. Owing to the great distance separating National Office from the scene of the Biennial meeting, it was deemed advisable to have accommodation arranged by those familiar with the facilities of such a "resort town" as Banff. The already very busy registrar of the Alberta Association of Registered Nurses, Mrs. Clara Van Dusen, has agreed to be responsible for seeing that our members are housed adequately during the time of the meeting. To facilitate this, the Public Relations Division of the Alberta Government has printed 2,500 (!!) application-for-housing cards that will be sent out from National Office upon receipt of completed pre-registration forms and fees. On these cards, which you will send directly to Mrs. Clara Van Dusen, you will indicate that you wish accommodation, what will be your method of arrival—by car, train, etc.—your time of arrival, and so on. May we say that, owing to a previous commitment, the Banff Springs Hotel has found it necessary to retain space for 100 non-C.N.A. guests. In the light of this, you would be wise to pre-register early and indicate if you definitely wish accommodation at the convention hotel. There is plenty of space elsewhere in the town but some people do feel that it is more desirable to be a guest in the hotel where the meetings are taking place.

Do not forget about the special trains. Arrangements are going ahead but the Canadian Pacific Railway will need to know whether or not you are interested.

The next time you have an opportunity to wish, such as being near a wishing well or seeing the new moon over your left shoulder, be sure to concentrate hard on an early 1954 spring in Alberta. How many tours of the park will be available depends upon the amount of snow still left from the winter. Those mountains just do not warm up very easily.

Have you seen the sunshine yellow stickers with "sky-blue" printing that National Office, your *Journal,* and provincial offices are using on their correspondence? They urge us all to pre-register early as well as, very subtly, foretelling the blue skies and bright sunshine you will find at Banff.

Newfoundland

Our president has been travelling to far places in the last two months. In the course of her work, she was able to visit Newfoundland just before going to the Congress of the I.C.N. in Brazil. It was a wonderful opportunity for her to consult with those nurses who were responsible for the preparation of the Bill that last spring became the Newfoundland Registered Nurses' Act. They are now in the midst of the hard work which goes into setting up a provincial office and getting the machinery of registration functioning. Our best wishes to the new association!

The I. C. N. Congress

Gradually the Canadian nurses, who attended the Congress in Brazil in July, are returning home. By the time this column is read, six weeks hence, they will be back at work and wondering whether it really was true that they had been in South America. One look at the souvenirs lined up on their desks or mantelpieces or adorning their fingers should convince them. It would be interesting to know how many alligator bags came back! However, aside from such frivolity, the pièce de résistance seems to have been

the passage of the I.C.N. Code of Ethics. In this time of international non-cooperation, it is rather wonderful to think that nurses are able to feel that their ethical conduct has basic principles which transcend national prejudices.

Schools of Nursing

The Canadian Nurse has a column elsewhere entitled "In the Good Old Days" which may be true in some ways but must be questioned in regard to what we offer many of our student nurses in these good new days. We have recently had the privilege of visiting two French-language nursing schools, one of which, the Hôtel-Dieu in Montreal, has a long history. The other has not yet opened.

With the tradition of Jeanne Mance, so well known to us all, giving them firm roots in the early development in Canada, the Sisters at Hôtel-Dieu are making history in this modern age. Their Jeanne Mance Pavilion, which houses the school of nursing, provides everything necessary for the up-to-date education of their students, both professionally and personally. Adequate classrooms and offices, along with a magnificent auditorium, solarium, and recreation facilities, leave little to be asked for by the school.

The not-yet-opened school was that of the new Maisonneuve Hospital. It is not often that a new hospital and a new school of nursing develop together. Tradition is admirable but the struggle to cast off its restrictions may become almost too much for those who try to institute changes so necessary to meet the health needs of our country. At Maisonneuve the school can be organized to care for the needs of the hospital and the community and the hospital organized to care for the needs of the school. Following the new pattern, students will have their formal studies in the first two years according to a block plan. They will be able to spend varying lengths of time on services in which they are particularly interested, in the third year. The office and classroom space would make many an educational director green with envy. And the furniture! Tailored to fit, efficient, and most attractive.

In our travels to schools of nursing we have seen something that should be of interest to many administrators and educators. It is a metal board called a "Graphdex" that has colored plastic signals which may be moved about. We have one in National Office that is most valuable in indicating enrolments, registrations, etc., day by day. In the particular school where it was seen it was used to indicate student postings on one board, the class schedule for the year on another, and the whereabouts of each student in relation to the residence in another. Remembering the large sheets of graph paper and the rulers that were never long enough, used in making master plans, this method really caught our eye.

Orientation et Tendances en Nursing

27e Congres Biennal

Bien que chaque numéro du *Canadian Nurse* nous apporte des informations concernant le congrès de Banff, maintenant il est temps de les revoir afin de savoir où nous en sommes.

Le Sous-Comité du Logement, nommé récemment, est très actif. A cause de la grande distance qui sépare le Secrétariat National de Banff, la question du logement fut laissée entre les mains de personnes au courant des accommodations qu'offre la ville touristique de Banff. Malgré ses occupations, la secrétaire-registraire de l'Association des Infirmières de l'Alberta, Mme Clara Van Dusen, a accepté la responsabilité de trouver un logement convenable pour tous nos membres durant le congrès. Pour faciliter sa tâche le Département des Relations Extérieures de l'Alberta a fait imprimer 2,500 cartes de logement. Ces cartes seront en-

voyées à toutes celles qui rempliront, avant le congrès, la formule d'inscription. Sur ces cartes, qui seront retournées directement à Mme Van Dusen, vous indiquerez le logement que vous désirez, vos moyens de transport (train, voiture, etc.), l'heure de votre arrivée et autres renseignements. Cent chambres à l'Hôtel Banff Springs seront réservées pour les touristes ne faisant pas parti du congrès. Devant ce fait, il semble prudent de s'inscrire le plus tôt possible et d'indiquer de façon précise si vous désirez loger à l'hôtel. Il y a bien d'autres endroits dans la ville où vous pourrez loger mais il y a des personnes qui préfèrent loger à l'hôtel où se tiennent les séances du congrès.

N'oubliez pas qu'il y aura des trains spéciaux mais, pour les organiser, le Canadien Pacifique doit savoir à l'avance si le congrès vous intéresse.

Si vous avez conservé cette habitude de votre enfance — de faire un désir en rencontrant un cheval blanc ou devant la pleine lune — n'oubliez pas le congrès de juin en Alberta. La variété des promenades, organisées dans le parc national de Banff, dépendra — lisez bien — de la couche de neige qui couvrira les montagnes. Ces glaciers sont lents à se réchauffer.

Avez-vous remarqué les papillons collés sur les lettres venant du Secrétariat National et de votre *Journal*? C'est une invitation à vous inscrire à l'avance. La couleur jaune et bleu est un présage du ciel bleu et du brillant soleil de l'Alberta.

Terre-Neuve

Notre présidente, durant ces deux derniers mois, a fait de grands voyages. Avant son départ pour le Brésil, elle s'est rendue à Terre-Neuve. Cette visite lui a donné l'occasion de rencontrer les infirmières qui ont préparé la Loi, devenue depuis le printemps dernier "La Loi des Infirmières Enregistrées de Terre-Neuve." Elles travaillent arduement à établir un bureau provincial et à organiser le rouage nécessaire à l'enregistrement des infirmières. Nos meilleurs voeux à cette nouvelle association!

Le Congres International des Infirmieres

Petit à petit, les infirmières qui ont assisté en juillet dernier au congrès du Brésil nous reviennent. Lorsque vous lirez ces pages, dans six semaines, elles seront au travail et se demanderont si vraiment elles sont allées en Amérique du Sud ou si elles ont fait un rêve. Mais un regard sur les souvenirs, placés sur la corniche ou ornant leurs doigts, suffira pour leur rappeler que ce fut une réalité. Il serait intéressant de compter combien de sacs d'alligator ont été rapportés!

Revenons aux choses sérieuses, l'adoption d'un Code de Conduite ou d'Ethique semble la chose la plus importante. Dans un temps où la coopération internationale est à l'ordre du jour, il est bon de penser que les infirmières sont capables d'émettre des principes en vue de combattre les préjugés nationaux.

Ecoles d'Infirmieres

Le *Canadian Nurse* a une colonne intitulée "Au Bon Vieux Temps." A certains points de vue c'était peut-être le bon temps, mais si l'on considère le cours que l'on offrait alors aux étudiantes il nous est permis d'en douter. Récemment nous avons eu l'avantage de visiter deux écoles d'infirmières de langue française. L'une, l'Hôtel-Dieu de Montréal, a une histoire ancienne. L'autre n'a pas encore ouvert ses portes. Suivant une tradition qui remonte à Jeanne Mance, le développement de l'Hôtel-Dieu marche de pair avec celui du pays. L'histoire du début de la colonie se continue et l'Hôtel-Dieu y a ajouté une nouvelle page — Le Pavillon Jeanne-Mance où l'école d'infirmières contient tout ce qui est nécessaire pour donner une éducation moderne aux étudiantes. Tant au point de vue confort qu'enseignement, il serait difficile de désirer mieux que les salles de classes, les bureaux, un magnifique auditorium, le solarium et le jardin sur le toit.

L'école de l'Hôpital Maisonneuve n'est pas encore ouverte. Il est rare qu'un hôpital et une école d'infirmières se développent en même temps. La tradition est une chose admirable mais souvent il est difficile de se débarrasser des restrictions qu'elle impose et ceux qui cherchent à établir des changements, conformés aux besoins de la santé et du pays, ont à lutter. A Maisonneuve, l'école a été organisée en vue des besoins de l'hôpital et de la communauté et l'hôpital tient compte des besoins de l'école.

Selon une tendance nouvelle, le programme d'étude sera donné durant les deux premières années du cours d'après un plan alternatif. Durant la troisième année les étudiantes iront dans les services les intéressant particulièrement. Les salles de classes et les bureaux sont la réalisation du rêve de toutes les directrices d'étude. Les meubles sont élégants, utiles et leur style selon l'architecture de la maison.

En visitant les écoles d'infirmières, nous avons vu quelque chose qui intéressera les directrices des études. C'est un tableau métallique, perforé, appelé "Graphdex," dans lequel on place des fiches mobiles de différentes couleurs. Au Secrétariat National nous possédons un de ces tableaux et nous le trouvons des plus utile pour indiquer les inscriptions, etc. Dans l'école où nous avons vu ces tableaux l'un servait à indiquer le roulement des étudiantes dans les différents services, un autre, le programme d'étude pour l'année, et un troisième indiquait à quel endroit de la maison ou au dehors se trouvaient les étudiantes. Le souvenir des longues listes et des lignes à tracer avec des règles toujours trop courtes nous a fait apprécier ces tableaux.

In Memoriam

Mabel V. (Miller) Abear, who worked at the Royal Inland Hospital, Kamloops, B.C., for 15 years, died on July 5, 1953, at the age of 71.

* * *

Edith (Crocket) Anderson, who graduated from The Montreal General Hospital in 1904, died earlier this year.

* * *

Phyllis Muriel (Spencer) Bogue, who graduated from the Royal Victoria Hospital, Montreal, in 1926, died at Kingston, Ont., on August 17, 1953.

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Marilyn J. (Appleby) Buschlin, who graduated from the Hamilton General Hospital, Ont., in 1947, died recently in B.C.

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Anna (Walsh) Greer, who graduated from St. Michael's Hospital, Toronto, in 1899, died recently in Toronto.

* * *

Jeannette Highsted, an Ontario graduate who practised nursing for nearly 40 years, for the greater part of the time in New York City, died on June 26, 1953, in New Westminster, B.C., at the age of 81.

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Catherine Kennedy, who graduated from St. Michael's Hospital, Toronto, in 1911, died on May 22, 1953, in Ontario. After nursing in Toronto for a number of years, Miss Kennedy went to New York to work. She returned to Canada in 1944.

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Isabel Lowrie, a graduate of the Calgary General Hospital, who for the past 20 years has served as matron of the hospital in Claresholm, Alta., died on June 15, 1953.

* * *

Annie M. Moore, who graduated from the General Hospital, Guelph, Ont., in 1912, died in Guelph in June, 1953.

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Reta (Seeley) Prager, a native of New Brunswick, who served overseas during World War II, died suddenly at her home in Toronto in June, 1953.

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Denise Provencher, who had almost completed her training at the Jeanne d'Arc Hospital, Montreal, died of injuries received in a motorcar accident on July 28, 1953, at the age of 20.

* * *

Helen R. Saunders, a native of Nova Scotia, who graduated from St. John's Riverside Hospital, Yonkers, N.Y., in 1910, died in Tillsonburg, Ont., on July 5, 1953, at the age of 69. After serving as night superintendent at the New York Lying-In Hospital for two years, Miss Saunders accepted the post of instructor at Kootenay Lake General Hospital, Nelson, B.C. Later she was superintendent of the Queen Victoria Memorial Hospital, North Bay, Ont., Payzant Memorial Hospital, Windsor, N.S., and Harbour View Hospital, Sydney Mines, N.S.

* * *

Louise Marian Usher, who graduated from Lady Stanley Institute, Ottawa, died suddenly on June 26, 1953, at the age of 61. Following World War I, during which she served overseas with the C.A.M.C., Miss Usher studied public health nursing at the University of British Columbia. She did graduate work at Rockefeller Medical Research Hospital, New York. Later, she was a supervisor at Mountainside Hospital, Montclair, N.J. Most recently she had been teaching at Barnard College, New York.

Focus on . . .

Survival by Cooperation

Dr. Ashley Montagu, in an article in the February, 1953, issue of *Nursing Outlook*, firmly and logically refutes the popular theory of survival of the fittest, in which every living creature is opposed to every other creature in a state of perpetual warfare. If you compete, and go on competing, says Dr. Montagu, you exterminate yourself — in other words, you must love your neighbor if you are to survive. Because we have been brought up in a culture interested in competition we do not easily take to the idea of cooperation. We say a baby is hostile, aggressive, wild, naughty, and obviously the most selfish being in the world with no consideration for anyone — an extreme egomaniac who must be disciplined if we wish him to become a reasonable human being. So we proceed to discipline him, which is our name for consistent frustration.

Babies are born expecting to be loved and to love others. We meet that love with frustration so they try to satisfy themselves by other available means — hostility and aggressiveness, which behavior we treat with more frustration. Infants *want* to cooperate with other people and be loved. It can be proved that when all of an infant's needs are adequately satisfied, he grows up to be a loving, harmonious, cooperative personality.

Many people have been deprived of these satisfactions and show predictable symptoms. The only way they can compel love is by acquiring power, so they are often found in high positions in our culture. Because they have never had love, they don't know how to love others. In their attempts to secure it, they do a tremendous amount of social and personal damage.

The origin of this desire to cooperate lies in the very beginnings of life. The relationship of all living things is one of interdependency arising out of the reproductive process and maintained at every level of life — from the unicellular to the most multicellular organism, man. In studying this basic biological interdependency we have learned much about the fundamental relationship between mothers and babies. For instance, the uterus contracts at a spectacular rate if the baby is left in cutaneous contact with the mother and even more rapidly if placed at the breast. The effect on the baby is noticeable, too. His breathing takes on a more advanced form and adjustments in the gastrointestinal tract are made much more rapidly than when mother and babe are separated. These, and many more factors show the biological cooperation that exists between mother and child, which we have constantly outraged. Cooperation is just another name for security — for love. Nurses can do much to make this common knowledge by actually living by the principle "love thy neighbor as thyself."

The Ill Effects of Bed Rest

Dr. Rex Lawrie, of Guy's Hospital, London, Eng., gives a graphic account of the ill effects of prolonged bed rest, in an article published in the *Nursing Times* of April 11, 1953. He says common experience has shown that when you go to bed your legs get weak and you feel "rotten" when you first get up. The longer you stay in bed and the more completely you are immobilized, the worse you feel later.

Dr. Lawrie describes this "demoralized helplessness in bed." The body is in a bent, crouched position with the weight mostly borne on the buttocks, sacrum, and heels — areas that are very liable to pressure necrosis. Contractures of joints are likely to develop in the shoulders, hips, knees and ankles. The plantar-flexed position of the ankle soon leads to contracture of the calf muscles, which is very crippling and difficult to remedy. Immobility leads to a sluggish circulation, hence the possibility of thrombosis. Hypostatic edema and consolidation of the lungs are probable consequences

of the reduced pulmonary function and less effective aeration. Disuse leads to gross wasting of muscles. Bed rest promotes distention of the bowels and constipation, both of which add to the patient's discomfort. Urinary stagnation and excretion of a high proportion of calcium from the skeleton promotes infection and the formation of urinary calculi. Urinary retention is very likely to develop.

It has been calculated that most patients spend 10 per cent of their time in pain and 90 per cent in boredom. Two wards of airmen suffering from virus pneumonia provided an interesting experiment during the last war. In one ward, convalescence followed the traditional pattern — when their temperatures had been normal a few days they were allowed up for short periods and, finally, after this purposeless routine, were returned to their units. In the other ward convalescence was pressed forward at a relentless pace. As soon as their temperatures were normal, the men got up and followed a strict, progressive program which kept them occupied all day. Their activities were steadily increased until by the tenth day their time was spent in an unbroken succession of cross-country runs, physical training and ping-pong tournaments alternating with lectures, picture shows and competitions. They were kept continuously occupied both physically and mentally. On return to their units the performance of the second group was 30 per cent higher than that of normal fit men and their relapse rate only one-third of the other group.

This shows what can be done in young men by a fairly rapid course of graded activity, with mental stimuli to keep them always interested and prevent boredom. Though this cannot be applied in every civilian hospital or to the aged, the principle is valid and in the patient's interest.

Reducing Hemorrhage Mortalities

A new drug, Mephyton, that has proved more effective than blood transfusions in saving victims of certain types of hemorrhages, has been added to the physician's armamentarium. The new agent promises to cut down drastically on the mortality rate among the thousands of victims of blood-clotting diseases who are being treated with certain anticoagulant drugs and other conditions of inadequate blood-clotting, resulting from vitamin K deficiency or abnormal utilization of vitamin K. Mephyton is in the form of an emulsion.

Victims of thrombosis are generally treated with anticoagulants which, though necessary, are potentially dangerous and sometimes result in hemorrhages that are difficult to stop. Thus, such treatments must be accompanied by time-consuming and costly tests to determine patients' reactions, particularly with respect to the time required for certain phases of blood coagulation.

The danger of anticoagulants has been particularly great because of the absence of a dependable agent for reversing the effects of overdosages, or for overcoming hyper-reactivity in patients with particular sensitivity to certain types of anticoagulants employed. Hitherto, the most reliable measure for counteracting hemorrhages, or potential hemorrhages of this kind, was the administration of whole blood. However, this counter-effect is both incomplete and of short duration.

In extensive clinical tests, it has been found that Mephyton is unfailing in its counteraction and, moreover, that this counteraction is detectable within 15 minutes. A safe degree of the particular phase of blood coagulation is usually achieved in 3 to 6 hours, protecting the patient against death from hemorrhage. Complete reversal of the anticoagulant effect takes place within 4 to 12 hours. Bleeding is usually checked in 3 to 6 hours, without the need of blood transfusions for the achievement of this effect.

— *Canadian Pharmaceutical Journal*

Nursing Sisters' Association

A very enjoyable picnic was held in July by the *Prince Edward Island Unit* at the summer home of Elsie Nicholson at Tracadie. Fourteen members enjoyed this outing.

Student Nurses

The Value of Psychiatric Affiliation to Me

JANE RICHMOND

THE PSYCHIATRIC AFFILIATION has been of great value to me. I know that when I go back to general nursing I will have more patience and a better understanding of the patient as an individual. I hope to be able to put myself in the patient's place and be able to understand and meet his needs.

All patients are in need of psychiatric nursing if we think of that term as an understanding of the personality factors operative in illness. Take for instance the psychoneurotic patients the nurse must care for in a general hospital. Instead of passing them off with "Just another neurotic" I hope to be able to meet their personality needs and establish a satisfactory nurse-patient relationship.

In our course we have taken the different types of approach. This should be very helpful in establishing a favorable nurse-patient relationship so that the patient has confidence in her nurse. Once this has been established the nurse can proceed to quell the patient's fears and, with tender loving care, rehabilitate her.

I also know now that there is no stigma attached to mental illness. I can intelligently discuss the different types of illness and help prepare a patient before entering a mental hospital by calming her fears.

Also I feel I have a better understanding of myself. I know now why I do and think certain things and how to overcome my idiosyncracies. Before we can understand the behavior of other people we must understand our own and I believe I have made much progress in this direction.

Also, I have learned a great deal about the therapies used in mental illness such as shock, insulin, hydrotherapy, and occupational therapy. I feel I could meet almost any emergency with a mental patient in a general hospital.

In summing up I will say that I believe this psychiatric affiliation is a very necessary part of and should be included in a nurse's training. Not only have I increased my learning but also have enjoyed the work.

Miss Richmond is a student nurse at the Hotel Dieu Hospital, Kingston, Ont.

Conquest of Scrub Typhus

TREVOR WILLIAMS

THE MEDICAL PROFESSION, like others, earns criticism more easily than it does praise. The public, unaware of the very complex factors that determine both the direction and outcome of research, finds it difficult to understand why such serious diseases as cancer, tuberculosis, and poliomyelitis, to say nothing of merely troublesome ones, such as the common cold and influenza, still largely resist every attack made upon them in spite of the immense battery of medical weapons now available. Such a view is both uninformed and ungenerous, for it altogether ignores the immense progress that has already been made. In countries where all available medical knowledge is being systematically applied, certain major diseases — such as cholera, typhoid fever, and smallpox — have virtually disappeared. Where

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devastating epidemics were within living memory accepted as inevitable, a single case of such diseases is now sufficient to excite newspaper comment.

Recently, yet another important stronghold of disease has fallen to medical science. This is scrub-typhus, a disease that takes a heavy toll of human life in the Pacific area. Like other forms of typhus it is caused by germs named after a medical man who gave his life in their investigation, as Rickettsias. This disease — known also as Japanese River Fever and Tsutsugamushi Disease — was proved to exist in Malaya in 1924 and was closely investigated at the Institute for Medical Research, in collaboration with Dutch workers in what was then the Dutch East Indies. A good deal of information was gained. The specific germ responsible was identified and it proved to be spread by the bites of mites carried principally by rats. This knowledge was in itself sufficient to enable a considerable check to be put on the disease, for it evoked public health measures designed to destroy both the mites and the rats which carried them. Virtually nothing, however, could be done for patients who actually contracted the disease, among whom the mortality was as high as 15 per cent.

The outbreak of World War II made the scrub-typhus situation much more serious for, like all the typhus fevers, unsettled conditions, upsetting public health routine, favor its spread. Moreover although it had hitherto been confined largely to the rubber plantations, the influx of troops on active service at once opened a completely new field to it. In fact, no less than 25,000 Allied servicemen contracted the disease during the last war. At once research was intensified. On the one hand, the already successful campaign against the mites was pursued more vigorously, notably by the introduction of the mite-poison dibutyl phthalate, developed by an Australian team of entomologists from basic work done by United States scientists in Florida. Smeared on clothes this proved deadly to mites and survived several launderings. Another chemical, benzyl benzoate, later proved equally effective. By this direct chemical attack on the mite alone incidence of the disease was cut by 75 per cent.

By 1945, therefore, the position had enormously improved in that the risk of infection had been much reduced by the campaign against rats and mites. Unfortunately, the lot of the actual sufferer remained unchanged. Little could be done for him except provide careful nursing. Then, almost overnight, the situation changed completely. From being a dreaded disease with a high mortality, scrub-typhus was reduced to one curable in 48 hours.

This change resulted from the introduction of chloromycetin, discovered in the United States in 1947 as a product of a mould found in a sample of soil from Venezuela. Very soon it was proved, in experiments with chick embryos and white mice, to be very active against the organism causing ordinary typhus and against other Rickettsias. As these diseases are of exceptional military significance, the Army Medical School in Washington became interested and asked whether a team of experts might be sent to Malaya to test the efficacy of chloromycetin against scrub-typhus in man. This suggestion was warmly accepted and the team arrived early in 1948, bringing one pound of chloromycetin, at that time all there was in the world. Within 24 hours the first test of the drug was made; 48 hours later the first patient was convalescent.

From this dramatic start there has been no looking back. Chloromycetin is now in general use in Malaya and elsewhere for the cure of scrub-typhus. It is easily given in capsule form by mouth and the treatment is complete in 24 hours.

Chloromycetin can prevent scrub-typhus as well as cure it, and is an invaluable safeguard for those who must venture into regions where the risk of infection is high. The expense of the drug, however, at present makes it impracticable to give general protection for long periods. Its introduction has nevertheless given new impetus to the search for a protective vaccine, for

it can be given to neutralize the unpleasant symptoms which normally follow vaccination with an attenuated strain of the germ. Combined vaccination and chloromycetin treatment can give, without unpleasant effects, immunity to the disease for as much as several years. The problem is, however, complicated by the fact that there are several strains of the organism and vaccination with any one of them usually gives immunity against the others for only a few months.

This work is a dramatic example not only of the way in which once dreaded diseases are being conquered, but of the way in which the battle is fought on an international front.

Progress in World Health

Dr. Brock Chisholm, retiring Director-General of the World Health Organization, in his last address to the Sixth World Health Assembly stressed the need for participation of *all* nations in the work of WHO. "The whole concept of this organization, all the principles included in its constitution, are based on this simple truth: in our shrunken world, health, like peace and security, is indivisible. Mankind's fight against illness, its major enemy, can be won only through concerted effort of all."

The word "progress" must be applicable in a total sense, if it is to have any meaning. Progress has not been made, says Dr. Chisholm, merely by restoring people to health

and working capacity, only to have them swell the ranks of the unemployed, the dissatisfied or the hungry. Economic and social factors are interdependent and gains in one specific field tend to lose their value unless accompanied by advances in other fields. Progress is assured only if the people, freed from disease, "are assured of capital investment for production and stabilized markets for distribution, if they are thus guaranteed sufficient work and, in addition, given adequate educational and cultural facilities for themselves and their children."

Modern man is facing a challenge that is without precedent in history. It is symbolized by the glaring contrast between the sacrifices we are forced to make to pile up instruments of destruction, and the insignificant amount of energy and money we spend for constructive purposes. Man must realize that ruthless competition, the old rule for survival has, at this stage of technological development, become synonymous with suicide. It must be replaced by cooperation based on mutual understanding, compromise and agreement.

It follows, then, that the welfare of our nation depends on the welfare of all nations. Each of us must develop, and help our children to acquire an equal degree of loyalty to all members of the world community as a whole, irrespective of differences in race, color, religion, or any other group characteristic.

The struggle for prestige is a primitive outmoded behavior pattern. Millions of people are learning to appreciate and admire the ability to compromise, to be helpful, to be concerned equally with the welfare of all people, to sacrifice something of individual, local or group interest for the common good. "These abilities," says Dr. Chisholm, "are gradually but ever increasingly recognized as the marks of developing maturity whether in nations or in individuals."

The most important contribution of WHO, by this criterion, does not lie in any reportable or measurable result it may have achieved. It is seen rather in the evidence it provides that men belonging to widely differing religious, social, and political systems can and do participate in genuine international cooperation.

" The time for courage, determination and action — even, it may be for martyrdom — is now, the place is here, wherever we may be and whatever our responsibilities at the moment. Every action, every word, works for, or against, the great ideal of peace on earth."

Be a Defensive Driver

A defensive driver is defined as "one who is careful to commit no driving errors himself, who makes allowance for the lack of skill or improper attitude on the part of the other fellow, and who does not allow hazards of weather and road conditions or the actions of pedestrians and other drivers to involve him in an accident.

"He keeps continually on the alert, recognizes an accident-producing situation far enough in advance to apply the necessary preventive action and concedes the right of way when necessary to prevent an accident."

The office of government is not to confer happiness, but to give men opportunity to work out happiness for themselves.

— CHANNING

Book Reviews

Adolescence and Youth, by Paul H. Landis. 461 pages. McGraw-Hill Co. of Canada Ltd., 253 Spadina Rd., Toronto 4. 2nd Ed. 1952. Price $5.50.

Reviewed by Pauline Capelle, Asst. Professor, School of Nursing, University of British Columbia, Vancouver.

The author is a sociologist and this book is presented primarily from the sociologist's point of view. According to him the adolescent and youth problem is a result of the urbanization of Western culture. The problems evolve out of the stresses and strains of the social structure with its long period of dependency, its emphasis on material values, its rapidly changing and confusing moral concepts, and its many choices of vocation. It is from these extraneous pressures that conflict arises rather than in the physical changes of the adolescent period.

The book is divided into four parts. The first discusses the implications of the culture on the development of the adolescent personality and indicates the mechanisms, both desirable and undesirable, that he uses to adjust to it.

The second unit, which deals with Attaining Moral Maturity, points out that morals are not instinctive but cultural, and that every matter to which our culture attaches great moral significance is contradicted by some other culture. Our rapidly moving western civilization is challenging traditional moral standards and there is no clear-cut pattern for youth to follow. This means that in many situations he has no standard and must determine his behavior from his own experience and beliefs.

To Landis, attaining moral maturity implies an ability to submit to authority so that the individual may be accepted into the associations of civilized man. In this regard he stresses the importance of the role of the family, school and church as the social agencies which have the greatest responsibility for helping the adolescent to accept and cooperate with the authority essential for group welfare. The social factors that work against the attainment of moral maturity are discussed. This is followed by an examination of the factors which cause the delinquency.

The third section deals with the question of Transition to Marital Adulthood and

examines the role of the adolescent and youth in the parental home; sex in adolescent-youth adjustments; sex education; and mate selection and marriage.

The fourth part shows the struggle for economic adulthood. The importance of economic forces on the adjustment of youth and finding a job are the major problems considered here. The role of the school in adolescent youth adjustment is also discussed.

This book, emphasizing as it does the influence of social factors in personality development, points out a path which, if followed, should help the adolescent youth to achieve maturity. We can manipulate social environment either for good or evil and as we sow, so shall we reap. To fail in our duty to youth is to fail in our trust to the future.

The book is well bound, with good quality paper and type that is clear and easy to read. The Table of Contents gives a comprehensive idea of the organization and continuity of subject matter. The questions at the ends of the chapters are valuable to stimulate discussion and the references provide good sources for further study. Most of the references are standard works and should be readily available. The majority of the tables are well selected and add to the text. The annotated bibliography of visual aids should be an asset in planning an effective teaching program. The inclusion of both name and a subject index is of value in the use of this volume as a reference text. The ideas are clearly and logically developed with a minimum use of professional jargon and should prove most helpful to teachers in the field of human relationships.

The Nursing Student Evaluates Her Teachers, by Loretta E. Heidgerken, R.N., M.S., Ed.D. 124 pages. J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1952. Price $3.50.

Reviewed by Mary L. Richmond, Educational Director, School of Nursing, Royal Jubilee Hospital, Victoria.

Dr. Heidgerken is a recognized authority in the field of nursing education. In this book she reports a study done to try "to determine what personal qualities of the teacher and the teaching activities the nursing student feels are most important in the school of nursing."

For this study 384 senior nursing students

in 37 American schools of nursing wrote two papers each — one describing " my best teacher" and one describing "my poorest teacher." From these, which were in the form of behavior descriptions rather than check lists, the author selected for discussion those characteristics mentioned most frequently in both the good and the poor teacher. Comparison is made between the desirable characteristics suggested by nursing students and by non-nursing students contributing to comparable studies in colleges. A rating scale for teachers in schools of nursing is presented as a development from the data.

Dr. Heidgerken points out in the introductory pages of her book that student evaluation of teaching does go on. Acceptance and crystallization of that evaluation can result not only in improved teaching but also in a better attitude of students to evaluation of themselves. The significance and validity of such evaluation, in spite of the lack of training of the student to judge good teaching, is established through statistical data drawn from a number of studies. The author's references to these studies, plus references to many other sources, not only suggest the wide research that went into the introductory chapters, but also provide a listing of much of the current literature designed to improve teaching both in schools of nursing and in general education.

The book is not intended as a text, nor is it a discourse on educational philosophy or methodology, yet the author's faith in students and in the democratic processes in education cannot be missed. It is a book in which the teacher hears, to a great extent in the students' words, her good and bad characteristics described. It is a book that would provide good material for study by an instructor or by an instructors' group. It is a book one enjoys.

Cues to Staffing Tuberculosis Units in Hospitals — A Guide for the Nursing Department. 28 pages. Prepared by the Tuberculosis Advisory Nursing Service of the National League for Nursing, Inc. In Canada, copies may be obtained from the Provincial Tuberculosis Associations. *Reviewed by Esther Paulson, Director of Nursing, Division of Tuberculosis Control, British Columbia.*

The topic — Staffing of Tuberculosis Units and Hospitals — is presented in a broad and informative manner. While the booklet is defined as a "Guide for the Nursing Department" it would be equally helpful to medical or lay administrators, particularly Chapter 2 (Factors affecting staffing pattern) and Chapter 3 (The bases for estimating staff quotas). The nursing service is treated as part of the whole organization and a logical explanation follows as to why factors often outside the jurisdiction of the nursing department directly affect the size and pattern of the staff that provides the nursing service. These related factors are dealt with under the following headings: Therapy program, hospitalization policies, hospital layout, other hospital services, and preventive program for protection of personnel.

Because nursing care for tuberculosis patients differs from the care of patients in general hospitals, the same time estimates for daily patient care cannot be used. The method of arriving at a unit of measurement for patient care in a 24-hour period is

clearly described, step by step. The need for a hospital to analyze its own needs and develop its own standards is also stressed because hospitals differ widely in physical set-up, personnel, routines, and equipment, as well as the type of patients in care. Tables of daily, weekly, and yearly calculations for staff personnel are included for tuberculosis units of different sizes — from 50 to 1,000 beds.

Chapter 3 is pertinent because the emphasis on "The Intangibles" and the need for help and guidance among the ambulatory and pre-discharge patients clarifies the concept of *adequate* nursing care for all classifications of patients. That nursing care requirements do not decrease proportionately as the need for physical care diminishes is explained in the following excerpts from statements in Chapter 3:

"To be constantly attuned to the moods of individuals who need nursing care over an extended period of time is the key to successful nursing of tuberculosis patients. This element of good nursing cannot be hurried or expressed in figures but staffing standards must provide for it...

"There are 'teaching moments' throughout the hospital experience of each patient which must be grasped and used to best advantage. Leeway in time is required to seize these opportunities for effective teaching."

In discussing the *predominant* features of nursing services needed by each group the following comment under "ambulant" is significant:

"Successful services to these patients who are now becoming relatively self-sufficient are characterized by their unobtrusive, friendly, professional qualities. Skilful supervision and guidance of these individuals call for a high degree of professional insight into interpersonal relationships which can foster constructive independence on the part of the patients — for these reasons noted, the ratio of registered nurses to other nursing personnel must be high."

From these quotations it will be seen that this booklet is valuable for the explanations as well as the calculations. It should be a definite help to administrators (medical and lay as well as nursing) in assessing the resources of their own institutions and in determining the numbers of personnel needed in the various categories to provide better and more comprehensive nursing care for the patients.

Handbook of Chest Surgery for Nurses, by J. Leigh Collis, M.D., B.Sc., F.R.C.S., in collaboration with L. E. Mabbit, S.R.N. 188 pages plus X-Ray Supplement. The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 3rd Ed. 1951. Price $2.40. *Reviewed by Katharine MacLennan, Director of Nursing, Provincial Sanatorium, Charlottetown, P.E.I.*

In Great Britain, the word "sanatorium" has been discarded for the term "chest hospital" since any patient suffering from a chest ailment, such as tuberculosis or carcinoma of the lung, is admitted to a chest hospital. With this idea in mind, the authors deal with all chest disorders.

The third edition maintains the high standard of the book. There is a vast amount of material presented in a well organized manner.

Again, as in the previous editions, the book is divided into two parts. The first section gives a comprehensive study of anatomy and physiology of the chest. The second deals with pathological conditions of this area and their treatments. Because of the changes in treatment brought about by antibiotics and new operative procedures, the chapter on pulmonary tuberculosis has been greatly changed.

The chapter on breathing exercises is particularly well explained and contains many helpful illustrations. The subject matter should be very helpful to nurses in institutions caring for chest cases, especially where the services of qualified physiotherapists are not available.

The part on anesthesia deals with the action of the various anesthetic agents and explains clearly the duties of the nurse during the different stages.

The text gives a clearer and broader understanding of the types of surgery that may be performed. The book, though detailed, is quite easily read and has a wealth of illustrative material which enhances its value and usefulness.

The book will be of great value to nurses engaged in tuberculosis nursing or in chest surgical departments of general hospitals as well as to students or graduate nurses taking courses at a sanatorium.

There is a loftier ambition than merely to stand high in the world. It is to stoop down and lift mankind a little higher.

— Henry Van Dyke

Montreal School for Nursing Aides

I regret that, in an article relating to the Montreal School for Nursing Aides that appeared in the July, 1953, issue of *The Canadian Nurse,* information regarding the support of the school was omitted.

It will be of interest to many, I am sure, to know that the funds for the organization and the operation of the school during the past years have come through the Province of Quebec Department of Health, from the National Health Grants Fund, and throughout the years of the school's existence those responsible for the National Health Grants program have shown an interest in the welfare of the school and a desire to be of assistance in every possible way.

FRANCES FISHER,
Director.

Ontario

THE FOLLOWING are staff changes in the Ontario Public Health Nursing Service:

Appointments: *Margaret Turner* (Hamilton Gen. Hosp.; University of Western Ontario certificate course; University of Toronto advanced course in administration and supervision) formerly Peel County health unit supervisor, as supervisor, Guelph; *Margarethe (Petersen) Petersen* (Kolding Hosp., Denmark, and University of Aarhus (Denmark) cert. course) as senior public health nurse, Perth Co. school health service.

Ruth Aiken (Hamilton Gen. Hosp. and U. of T. general course) to Leeds and Grenville health unit; *Jean Andrews* (St. Joseph's Hosp., Peterborough, and U. of Ottawa cert. course) formerly with St. Catharines-Lincoln health unit, to Fort William and district health unit; *Kathleen (Briggs) Gies* (St. Michael's Hosp., Toronto, and U. of T. gen course) to Forest Hill Village; *Jane Hinton* (Westchester School of Nursing, Valhalla, N.Y., and B.S., New York U.) to Peel Co. health unit; *Audrey (Anderson) Lyle* (Women's College Hosp., Toronto, and U. of T. gen. course) to Halton Co. health unit; *Margaret (Hallowell) Martin* (Toronto Gen.

Hosp. and U. of T. gen. course) to Simcoe Co. health unit; *Denise Tremblay* (School of Nursing, U. of Ottawa, and U. of O. cert. course) formerly with Porcupine health unit, to Prescott and Russell health unit.

Resignations: *Frances Fish* as Halton Co. health unit supervisor; *Alice Klugman* as supervisor, Guelph; *Mary (Ranney) McMane* as senior public health nurse, Perth Co. school health service; *Kathleen (Magee) Hastings* from Kent Co. health unit; *Roberta Mathie* from Dufferin Co. health unit; *Irene McCarty* from St. Catharines-Lincoln health unit; *Ruth (Roszell) Neilson* from Simcoe Co. health unit; *Violet Sam* from Lambton health unit; *Helen Servage* from Wellington Co. health unit; *Kathleen Terrill* and *Grace Walters* from Stormont, Dundas and Glengarry health unit; *Pauline Tomlin* from Brant Co. health unit; *Sally (Stillman) Wilkins* from Oxford health unit.

Victorian Order of Nurses

THE FOLLOWING are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Calgary: *Kathleen Hill* (Saskatoon City Hosp.) and *Shirley Smith* (Kingston Gen. Hosp.). Chatham, Ont.: *Dorothy Prentice* (Toronto Western Hosp.). Hamilton: *Ruth Haines* (St. Joseph's Hosp., Hamilton) and *Helen Thorner* (University of Western Ont.). London: *Patricia Gagen* (Victorian Hosp., London). Medicine Hat: *Margaret Bath* (University of Alberta Hosp.). Niagara Falls: *Colleen Birmingham*. North York, Ont.: *Ille Toolse* (Ottawa Civic Hosp.). Ottawa: *Jacqueline Girard* (St. Vincent de Paul Hosp., Sherbrooke, Que.). Owen Sound: *June Fredin* (Victoria Hosp., London). Saint John, N.B.: *Dorothy Stacey* (Royal Victoria Hosp., Montreal). Sudbury, Ont.: *Marie Hurtibise* (Notre Dame Hosp., Montreal). Timmins: *Ella Johnston* (Ottawa Civic Hosp.). Windsor, Ont.: *Mrs. Patricia Hemple* (Victoria Hosp., London).

Reappointments — Brockville: *Catharine Miller* in charge. Burnaby, B.C.: *Pauline Paterson*. Elphinstone, B.C.: *Elizabeth Godwin* in charge. Kentville, N.S.: *Mrs. Rod Grant* in charge. Kirkland Lake, Ont.: *Margaret Jones* in charge. Leamington, Ont.: *Alice McDonald* in charge. Newcastle, N.B.: *Ruth Garnham* in charge. Nia-

gara Falls: *Ruth (Stuart) Ferguson.* Ottawa: *Pacquerette Boily, Dorothy McVeigh, Johanne Theill.* Pointe Claire, Que.: *Stella Warwick* in charge. Sackville, N.B.: *Vera Hamilton* in charge. Smiths Falls, Ont.: *Sheila Rymer* in charge. Surrey, B.C.: *Alsie Batten.* Truro, N.S.: *Nora Stratford* in charge. Victoria: *Marion Brown.* Windsor, N.S.: *Mrs. L. May Dimock.* Yarmouth, N.S.: *Jean Thornber* in charge.

Transfers — *Mabel Birtch* from Medicine Hat to Calgary; *Marjorie Rideout* from Smiths Falls to Montreal.

Resignations — Calgary: *Mary Hoggarth.* Hamilton: *Mrs. A. McClay.* Kentville: *Jean Forrest* in charge. London: *M. Hargroft.* Ottawa: *L. McMullen.* Pointe Claire: *Thérèse Farmer* in charge. Ste. Anne de Bellevue: *Marcelle Jutras.* Toronto: *Sadie Chevannes, Sheila Hart.*

News Notes

NEW BRUNSWICK

MONCTON

Regular meetings of the Nurses' Hospital Aid of Moncton Hospital were presided over by Mrs. K. Carroll. It was reported that a large number of the members attended Vesper Services in May. Mrs. A. Hans was appointed delegate to the Mental Health Association and a report was received from Mrs. H. Henderson on a rummage sale held by the Aid. The summer home of Mrs. M. Perry at Hopewell Cape was the scene of the June meeting when Mrs. J. Morrell gave an account of the successful tag day and Mrs. Perry spoke of the Maritime Hospital Association meeting she had attended at St. Andrews as delegate with Mrs. K. Lamb.

Mrs. Perry was convener of the dinner and dance sponsored by the Aid, honoring the 1953 class of the hospital's School of Nursing. In charge of the program was Mrs. G. Whelan. Mrs. J. Innes, in the absence of Mrs. Carroll, welcomed the guests. The invocation was given by Mrs. N. Smith while Mmes Innes, Perry, and Miss S. Steeves participated in the various toasts. Dr. R. Fitch was soloist, accompanied by Mr. R. Bailey. At the dance, Mmes Innes and Perry received the guests.

NOVA SCOTIA

KENTVILLE

The nursing staff of the Blanchard-Fraser Memorial Hospital was entertained at tea recently by members of the Junior Ladies Hospital Auxiliary.

Mmes L. Spencer and S. Zirkel of the

staff of the Nova Scotia Sanatorium took a two-week refresher course on Nursing Team Procedure in Hamilton, Ontario. Ardath Young is taking a course at the McGill School for Graduate Nurses. J. Forrest has resigned from the V.O.N. to take a post with a welfare organization in Toronto.

ONTARIO

DISTRICT 2

WINGHAM

The local golf club was the scene of an enjoyable gathering of the General Hospital graduate registered nurses' group held at the end of June. The following officers were elected, M. E. Adams presiding:

Honorary president, Mrs. G. Gillespie; president, Mrs. W. Ringrose; secretary-treasurer, Mrs. N. MacDonald. Committees: Lunch, Mmes D. McKenzie, B. Walden, C. Finlay; sports, Mmes S. Gallaher, S. Moffat.

DISTRICT 3

Guelph General Hospital

The alumnae association has had an active year, the annual meeting being held in January when L. Campbell was re-elected as president. A tea and Penny Sale proved a success in March. In May, Mr. Murray McKettrick, editor of the *Orangeville Banner*, was guest speaker at the annual alumnae dinner in honor of the 23 graduates of the School of Nursing. At the graduation exercises a prize for proficiency in obstetrical nursing was presented by the association. The June meeting took the form of a well attended picnic.

QUEBEC

MONTREAL

Royal Victoria Hospital

It is expected that the official opening of the new addition of the Allan Memorial Institute will take place in October.

Additions to the staff include: Assistant head nurses — E. Murray, Ward G, and L. Hartle, Ward M; O.P.D., M. Green, Mrs. J. Bert. H. Tidmarsh did relief work at the Ross Pavilion during the summer. C. Mason and M. Jardine have resigned. Recent visitors to the N.S.O. were: R. (Lyle) Heimpel, I. (McAllister) Pierpont, A. (McLeod) Wade, M. Dolphin.

SASKATCHEWAN

SASKATOON

St. Paul's Hospital

Though sorry to bid farewell to Sr. Superior B. Bezaire who has left for Edmonton, St. Paul's is happy to welcome an old friend as its new superior — Sr. A. LaChance.

Thirty-seven "Feb. '53" student nurses received their caps in July and will write their qualifying examinations this fall. Three students represented the Sodality at a summer school held at Lebret. A. Redmond convened a very successful garden party, sponsored by the School.

Positions Vacant

Advertising Rates—$5.00 for 3 lines or less; $1.00 for each additional line.

Supt. for 125-bed hospital with small Training School. Apply Sec., Board of Trustees, Prince County Hospital, Summerside, P.E.I.

Nurse Supt. for new 56-bed General Hospital. Separate residence with suite. 1 mo. holiday after 1 yr. plus statutory holidays. Salary open. Apply, giving qualifications & experience with references, Miss L. Pockett, Acting Supt., General Hospital, Morden, Manitoba.

Matron for 7-bed hospital in friendly, active southern town, 12 miles from U.S.A. Salary: $255 per mo. with $5.00 increment each 6 mos. plus $5.00 per 6 mos. previous experience — up to $285. Board: $15 per room in modern residence & 25 cts. per meal. 3 wks. vacation. 12 days sick leave. Skating, skiing, curling, tennis; lake nearby, modern theatre. New hospital to open late fall. Also **Trained Nursing Assistant (1).** Salary: $135 per mo. minus $15 per room & 25 cts. per meal. Apply G. Morrison, Sec.-Treas., Union Hospital, Rockglen, Sask.

Matron & General Staff Nurse immediately for 16-bed hospital. Salaries: $255 & $210 gross respectively plus 30 days holiday after 1 yr. service. Sick leave & other benefits. Separate residence. Apply L. Fetter, Sec., Union Hospital, Eastend, Sask.

Matron & General Duty Nurse immediately. 20-bed hospital in B.C. Southern Interior. Town on railways & main highway. Salaries: $275 & $220 respectively. Annual increments, $5.00. 28 days vacation. Apply Lady Minto Hospital, Ashcroft, B.C.

Director of Nursing for 400-bed modern General Hospital. Complete responsibility of nursing care & nursing education. Ideal location in attractive Southern Ontario city. Apply Administrator, Kitchener-Waterloo Hospital, Kitchener, Ont.

Asst. Director of Nursing for 90-bed General Hospital in B.C. Cariboo District. Services required from present time till Sept. 1954. Apply Director of Nursing, Prince George & District Hospital, Prince George, B.C.

Head Nurse for Nursery in new Obstetrical Dept. Nursery supplied with Armstrong incubators, oxygen & suction, mobile cubicle units. Salary commensurate with qualifications & experience. Also **General Duty Nurses** for same unit. 3 rotating shifts. 44-hr. wk. 8 statutory holidays. Salary: $195 per mo. with differential for post-graduate study. Apply Director of Nursing, McKellar General Hospital, Fort William, Ont.

Public Health Nurse III for schools, homes or clinics. Must be graduate of an accredited School of Nursing & have successfully completed at least 1-yr. approved course in Public Health Nursing. Bachelor's Degree desirable but not required. 40-hr. wk. Salary: $3,783-4,498. Apply Flint Civil Service Commission, City Hall, Flint, Mich.

Registered Nurses for General Duty in active General Hospital. Commencing salary: $150 per mo. Rotating shifts. Vacation, sick time & 7 statutory holidays. Apply Supt., General Hospital, Palmerston, Ont.

Registered Nurse for General Duty in Brome-Missiquoi-Perkins Hospital, Sweetsburg, Que. Small general hospital about 65 miles from Montreal, connected by excellent train & bus service. New hospital expected to be completed next spring. Salary: $140 per mo.; full maintenance. 3 increases of $5.00 per mo. at 6-mo. intervals. 12 days sick leave. 30 days vacation after 1 yr. service. Day duty — broken shift. 5½-day wk. 2 straight 8-hr. shifts: 3-11 & 11-7. 1 night off per wk. Blue Cross paid. Apply Mrs. E. Paintin, Supt.

Registered Nurses. Opportunities are available for positions with Sanatorium Board of Manitoba. Salary range: $200-230 per mo. depending on qualifications & appointment. Board, room & laundry supplied for $39 per mo. Good hours & working conditions. Generous vacations, group insurance, all statutory holidays & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

General Duty Staff Nurses for 515-bed General Hospital. 40-hr. wk. Beginning salary: $260 per mo. with advancement to $285; $20 additional for evenings & nights. Hospital & School of Nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

General Duty Nurses for 650-bed Teaching Hospital in Central California. Salary: $273-320 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market, Stockton, California.

THE MONTREAL GENERAL HOSPITAL

The Montreal General Hospital requires:

(1) ***General Staff Nurses.***

(2) ***Operating Room Nurses.***

An interesting variety of experience is available to **Registered Nurses,** both on the Wards and in the Operating Room.

For further information apply to:

The Director of Nursing, The Montreal General Hospital,
60 Dorchester St. East, Montreal 18, Quebec.

Registered General Duty Nurse to act as **Asst. Matron** with view to becoming Matron. Gross salary: $240 per mo. Single room in modern nurses' residence. Apply, giving experience with references, Supt. of Nurses, Union Hospital, Hafford, Sask.

General Duty Nurses & Dietitian for 500-bed hospital. 40-hr. wk. Good personnel policies & salary. Apply Director of Nursing, St. Joseph's Hospital, Victoria, B.C.

Registered Nurses for 22-bed hospital. Salary up to $190 per mo. in accordance with experience & ability. Maintenance — $25 per mo. Laundry free. 44-hr. wk. — rotating shifts. 28 days holidays with pay after 1 yr. service. 7 statutory holidays. Apply, giving qualifications & references, Supt., Bruce Peninsula & District Memorial Hospital, Wiarton, Ont.

Director of Nurses & Principal of School of Nursing for 117-bed General Hospital. Post-graduate course in administration or equivalent experience required. Salary open. Suite in modern residence. Construction of new 150-bed hospital under way. Apply, giving details of education, qualifications, experience, enclosing recent photo. Administrator, Jeffery Hale's Hospital, Quebec City, Que.

Nursing Instructor at once. Salary: $243.36-293.36 depending on qualifications & experience, preferably with Psychiatric Nursing preparation. 44-hr. work wk. Uniforms supplied. Modern residence. $30 charge per mo. for perquisites. Excellent holiday, sick leave & pension benefits. Apply, stating qualifications & experience, Supt. of Nurses, Provincial Mental Hospital, Ponoka, Alta.

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

Supervisor (experienced) interested in teaching & administration of hospital serving Extended Illness (516 beds). (Graduate & Nursing Aide staff.) Salary depending on qualifications. Apply Supt., Queen Elizabeth Hospital, 130 Dunn Ave., Toronto 3, Ont.

Supervisor for Out-Patient Dept. & Asst. Nursing Arts Instructor for Civic Hospital, Ottawa, Ont. Good personnel policies. Pension plan after 2 yrs. Apply Director of Nursing.

Clinical Supervisor (qualified) for Jeffery Hale's Hospital, Quebec City, Que. For details apply Director of Nurses.

Clinical Supervisor for Psychiatric Unit, University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Operating Room Supervisor & Asst. Night Supervisor for 125-bed hospital. Straight 8-hr. day, 44-hr. wk. For further information apply Supt. of Nurses, Children's Hospital, Winnipeg, Man.

Operating Room Supervisor (special preparation preferred). Also **Dietitian & Night Supervisor** for 100-bed hospital. Salary depends on qualifications & experience. Apply Soldiers' Memorial Hospital, Campbellton, N.B.

Supervisor for small Eye Ward with operating experience. Salary: $240 with credit for experience & post-graduate work. Annual increments, cumulative sick leave, 28 days annual vacation. 40-hr. wk. & 11 statutory holidays. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Asst. Administrative Supervisor for Operating Rooms for University of Alberta Hospital. Salary: $225 per mo. plus meals & laundry. 44-hr. wk. 11 statutory holidays. 31 days vacation. Cumulative sick leave. Pension plan. Apply Director, School of Nursing, University of Alberta, Edmonton, Alta.

Asst. Head Nurses for 60-bed Pediatric-Orthopedic Hospital. Also **Operating Room Supervisor** (fully experienced). Apply, stating qualifications & experience, Director, Shriners' Hospitals for Crippled Children, Montreal 25, Que.

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Staff Nurses & General Staff Nurses for new 112-bed Maternity Bldg. Gross monthly salary min. staff: $225. General Staff: $200. Deduction of $25 for meals & laundry. Credentials & experience given consideration in employing staff. Apply Supt. of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

Registered Nurses for General Duty, Caseroom & Eye Ward of 500-bed General Hospital. 5-day wk. & excellent personnel policies. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Registered Nurses for General Duty in 48-bed hospital. Salary: $175 per mo. with full maintenance. $10 bonus every 6 mos. 3 wks. holiday with pay. 48-hr. wk., rotating shifts. Apply Matron, Municipal Hospital, Wainwright, Alta.

Registered Nurses for General Duty in 200-bed hospital in Niagara Peninsula. Gross salary: $210 — afternoons, $220; nights, $215. Increments & return train fare after 12 mos. Also **Certified Nursing Assts.** Salary: $160. Regular 8-hr. shift. 3 wks. vacation. 8 statutory holidays. Cumulative sick leave. Accommodation available in attractive residence. Apply Director of Nursing, County General Hospital, Welland, Ont.

WANTED

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REQUIRES

(1) *Assistant Operating Room Supervisor.*

(2) *General Duty Nurses for Operating Room* (with or without experience).

Further information may be obtained from:
Supt. of Nurses, Victoria General Hospital, Halifax, Nova Scotia.

Registered Nurses for General Duty in 90-bed General Hospital in city of 10,000, 50 miles from St. Paul, Minn. Excellent streamliner rail service to St. Paul & Chicago. Base salary: $235 plus four $5.00 semi-annual increases. Additional $10 for night & $15 for relief shifts. 40-hr. wk. 3 wks. vacation paid after 1 yr. service. Paid holidays, sick leave & other benefits. Apply Director of Nurses, St. John's Hospital, Red Wing, Minnesota.

Registered General Duty Nurses immediately for active 31-bed hospital. Comfortable living accommodation. Salary: $200 with free maintenance. 3 wks. vacation after 1 yr. Apply Supt., Little Long Lac Hospital, Geraldton, Ont.

Registered or Graduate Nurses for 65-bed hospital. Salary: $150 per mo. plus full maintenance. Very pleasant surroundings near lake. Good time off. 4 wks. vacation. Starting 44-hr. wk. in Sept. Apply Supt., Alexandra Marine & General Hospital, Goderich, Ont.

Registered Nurses for General Duty in 600-bed hospital for Tuberculosis. Initial gross salary: $185; additional salary for operating room, surgical floor & night duty. Board, room, laundry available — $33 per mo. Fir further information apply Director of Nurses, Beck Memorial Sanatorium, London, Ont.

Nurse (1) with O.R. experience — salary: $230 per mo. & **General Duty Nurses** for 110-bed hospital. Starting salary: $220 per mo. for B.C. Reg. with annual increase up to $25; less $52.50 for board, room, laundry. 18 days cumulative sick time annually. 28 days vacation after 1 yr. 10 statutory holidays. Excellent golf, swimming, skiing & other recreational facilities. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

Nurses (male & female). Also **Dietitian & Asst. Supt.** Apply, stating qualifications, experience, salary expected, Supt., Lady Minto Hospital, Cochrane, Ont.

Nurses — vacancies for all grades of nurses & other hospital personnel. Apply International Employment Agency, 531 E. Grand Blvd., Detroit 7, Michigan. (Phone WAlnut 1-8543).

Nurses interested in care & rehabilitation of those patients in later years of maturity. Starting salary: $240 per mo. 8-hr. day, 40-hr. wk. 3 wks. vacation. 6 paid holidays. New hospital affiliated with Western Reserve Medical School & associated with University Hospitals. Apply Director, Benjamin Rose Hospital, 2073 Abington Rd., Cleveland 6, Ohio.

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The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $226.50 as minimum and $263.25 as maximum, plus shift differential for evening and night duty.

Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

General Duty, Operating Room & Maternity Nurses. Salary: $182.50 for recent graduates. 1 meal, laundry. 8-hr. day, 44-hr. wk. — straight shift. $15 differential evenings — $10 nights. Vacation, sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

General Duty Nurses for 920-bed General Hospital. Starting salary: $190-210 per mo. plus meals & laundry. Credit for past experience, annual increments. 44-hr. wk., rotating shifts. Statutory holidays, 21 days vacation, cumulative sick leave, hospitalization subsidized, pension plan. For further information apply Supt. of Nursing Service, University of Alberta Hospital, Edmonton, Alta.

General Duty Nurses by early Sept. for United Church of Canada hospital, 300 miles north of Vancouver on B.C. coast. Salary: $210 per mo., less $40 for board, room, laundry of uniforms. 2 annual increments of $5.00 per mo. Sick time, 1½ days per mo. cumulative. 1 mo. annual holiday plus 10 days in lieu of statutory holidays. Transportation to Bella Bella refunded after 1 yr. Apply Matron, R. W. Large Memorial Hospital, Bella Bella, B.C.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $240-270. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses for 200-bed General Hospital in B.C. Interior. Starting salary: $225. Annual increments. Credit for past experience. 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses. Salary: $173.23 (one hundred seventy-three dollars & twenty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

General Duty Nurses for active 60-bed General Hospital. 3 wks. vacation with pay. 7 statutory holidays. Sick leave cumulative. Starting salary gross: $190 per mo. with increments every 6 mos. Apply Supt., General Hospital, Strathroy, Ont.

General Duty Nurse for large Municipal Hospital. Promotional opportunities. 44 hr. wk. Retirement benefits. Salary: $297-354 per mo. Apply Flint Civil Service Commission, City Hall, Flint, Michigan.

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Supt. for Chesley & District Memorial Hospital. 20 beds & nursery; quite new building, as hospital has operated only 5 yrs.; fully equipped. Salary: $225 per mo.; full maintenance. Holidays, etc. Write or phone the Sec., Clayton Schaus, Chesley, Ont.

General Duty Nurses. Base pay: $245; for afternoons & evenings, $255. Rooms available at nurses' home. Bed capacity, 428. If interested please contact Director of Nursing Service, St. Vincent's Hospital, Portland 10, Oregon.

General Duty Registered Nurses (2) — One interested in Operating Room work — for Groves Memorial Hospital, Fergus, Ont. Salary: $155 per mo. plus full maintenance. 3 wks. vacation after 1 yr. service. Statutory holidays. Salary increases at 3 & 9 mos. Apply J. M. Gifford, P.O. Box 731, Fergus, Ont.

Certified Nursing Assistants (2) for Groves Memorial Hospital, Fergus, Ont. Salary: $100 per mo. plus maintenance. Increases at 3, 6 & 9 mos. 2 wks. vacation after 1 yr. Statutory holidays. Apply J. M. Gifford, P.O. Box 731, Fergus, Ont.

Supervisor — evening (3-11) for 340-bed General Hospital near two universities. Excellent personnel policy. Salary open. 40-hr. wk. — overtime pay. 4 wks. vacation & 30 days sick leave after 1 yr. In-staff educational program. Social security; Blue Cross. 8 paid holidays. Pleasant working surroundings. Advanced preparation encouraged. Apply Director of Nursing Service, Presbyterian Hospital, 27 South Ninth St., Newark, 7, New Jersey.

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General Staff Nurses. Medicine, surgery, obstetrics, nursery, operating room. Salary: $215-265 in 6 increments. 340-bed General Hospital near two universities. Excellent personnel policy. 40-hr. wk. — overtime pay. 4 wks. vacation & 30 days sick leave after 1 yr. In-staff educational program. Social security; Blue Cross. 8 paid holidays. Pleasant working surroundings. Advanced preparation encouraged. Apply Director of Nursing Service, Presbyterian Hospital, 27 South Ninth St., Newark 7, New Jersey.

General Staff Nurses for mixed services on private & semi-private wards in 378-bed hospital. Residence accommodation if desired. Apply Director of Nursing, General Hospital, Brantford, Ont.

General Duty Nurses (1) or (2) for 20-bed hospital in beautiful Arrow Lakes district of British Columbia. Apply, giving experience, references & qualifications, **Matron,** Arrow Lakes Hospital, Nakusp, N.B.

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1411 Crescent St., Montreal 25, Que.

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Beauty Magic for Busy Nurses!

● Must a nurse be a perfectionist? Sometimes it looks that way! So many people seem to expect her to have an angel's voice, an angel's touch, and the complexion of an angel, too!

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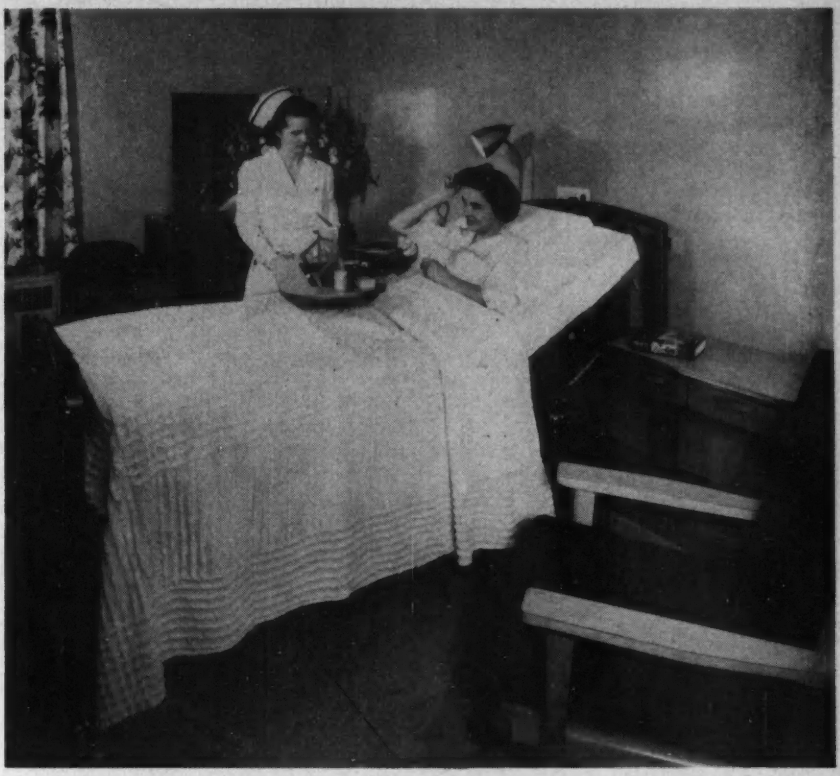

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Between Ourselves

Numerically, the membership of the ***Saskatchewan Registered Nurses' Association*** places fifth in size among the provincial associations with approximately 2,300 members. Strategically, Saskatchewan has never been considered one of the possible danger zones from the Civil Defence standpoint. Thus the nurses have been more concerned with the study of the provision of reception areas for injured persons from other parts of the land. Economically, Saskatchewan is dependent on many climatic factors that may affect the crops of this largely agricultural province.

Professionally, strong leadership has forged a progressive, far-sighted organization that is ready to throw the weight of its influence behind such experimental patterns as the new central school programs that commenced operations within the past year. Less dramatic than some of the other experiments in nursing education developed in the immediate post-war period, the basically sound elements in their structure presage a long future for these schools.

Presiding over the destinies of the provincial association this year is **Grace A. Motta,** a native of Moose Jaw, who graduated from the school of nursing of the Winnipeg General Hospital and received her certificate in teaching and supervision from the University of Toronto. For the past ten years Miss Motta has been director of nursing at Moose Jaw Union Hospital. Her presidential address at the 1953 convention of the S.R.N.A. was a call to *all* the nurses in the province — not just those in executive positions — to demonstrate their right to be called truly professional. In a somewhat abridged form, this address is presented here as our guest editorial.

* * *

We have been gratified to learn, from the directors of some of the nursing services noted in our August editorial, of the response from many nurses who have expressed their interest in working in some of the more ***remote areas of our country.*** Talking recently to several new graduates whose predominant urge at the moment appears to be to travel, we emphasized again the fact that enrolment in these various nursing services is an excellent way to see new and off-the-usual-routes parts of Canada. There is only one drawback in having these attractive, wideawake, young nurses going into these more distant areas. There seems to be such a large number of personable bachelors there!

* * *

We commend, especially to those nurses who are themselves in contact with young children or who work closely with the mothers of these small fry, the description of the ***new container for pills*** and other substances, hurtful to youngsters, written by **Claire Halliday.** We decided to test the manufacturer's claim that children under five could not open the container so invited a youthful neighbor, who is exceedingly dextrous for a four-year-old, to experiment. His chagrin and bafflement were the only proof we needed of the value of the "Kidipruf."

* * *

This month we bring you the paper presented by ***Gladys J. Sharpe*** at the Congress of the International Council of Nurses dealing with ***New Trends in Curricula for Schools of Nursing.*** At the same session Miss Julieta V. Sotejo, dean of the College of Nursing, University of Philippines, and president of the Filipino Nurses' Association, presented a paper bearing the identical title. As you read Miss Sharpe's paper this month and Miss Sotejo's in December bear in mind some of the pertinent points that were brought out in the subsequent discussion:

1. With all the new trends in nursing education, we must never lose sight of the important fact that nurses must be *soundly prepared to nurse.*
2. Nurses must *want* changes in time-honored patterns of nursing education before they will join in a concerted effort to move it from where it is now to where many of us would like it to be — under the egis of the university.
3. Changes must be made throughout the whole program so that it does not become lopsided. At the end of 28 months the students' skill and judgment are still likely to be weak despite the fact she has completed all of the theoretical instruction. She cannot develop full skills without constant supervision over a longer period of time.

New Products

Edited by DEAN F. N. HUGHES

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

DIAGNEX

Manufacturer—E. R. Squibb & Sons of Canada Ltd., Montreal.

Description—Quinine carbacrylic resin for the detection of gastric anacidity without intubation. Each package contains the quininium resin for the test and a capsule of caffeine sodium benzoate to stimulate gastric secretion.

Indications—As a test for achlorhydria as an aid in the diagnosis of cancer of the stomach, pernicious anemia, and gastric polyps.

Administration—Follow directions on package.

UNITOL

Manufacturer—Frank W. Horner Limited, Montreal.

Description—Compressed tablets containing d-amphetamine phosphate, 5 mg.; pentobarbital, ½ gr.

Indications—Tense, anxious, worried patients. Depression and mental fatigue. As an adjunct to active psychotherapy.

Administration—1 tablet two or three times daily is suggested for the average patient.

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Manufacturer—Lederle Laboratories Division, North American Cyanamid Limited, Montreal.

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Administration—Intramuscularly. As an antidote for folic acid antagonists, 1 or 2 cc. (3 mg. to 6 mg.) daily. The initial dose should be 1 cc., given immediately following the dose of the antifolate. Subsequently, should be given at gradually increasing intervals after the folic acid antagonist up to 1 or 2 hours, depending upon the desired action of the folic acid antagonist.

If the folic acid antagonist has been withdrawn because of severe bone marrow depression, Leucovorin should be administered in doses of 1 cc. once or twice daily until the blood picture approaches normal or as nearly normal as is expected in the specific patient. May also be administered in conjunction with folic acid antagonist therapy to prevent cytotoxic reactions that might be engendered by the antifolate.

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Manufacturer—Smith Kline & French Inter-American Corporation, Montreal.

Description—Contain phenobarbital, 1 gr. or 1½ gr., distributed among scores of tiny pellets with varying disintegration times. Medication is released continuously and uniformly over a span of 8 to 10 hours, with therapeutic effectiveness of the phenobarbital lasting for approximately 10 to 12 hours. Provides three significant advantages: continuous sedation throughout day or night with one oral dose; no excessive drowsiness or nervous breakthrough; convenience of a single daily dose.

Indications & Recommended Dosage—All conditions in which continuous sedation is beneficial. Eskabarb Spansules, particularly the 1½ gr. strength, are a practical dosage form for night-time sedation or mild hypnosis. Eskabarb Spansules 1 gr. replace ¼ gr. phenobarbital q.i.d. The 1½ gr. size replaces ½ gr. phenobarbital t.i.d. *Note*: Eskabarb Spansules should not be given to patients known to be sensitive to barbiturates.

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Dosage—As an antipruritic, may be applied to the affected area as frequently as required, usually 2 to 3 times daily. As a scabicide, 1 or 2 applications over the skin of the entire body, except the face and the scalp, should be made. An interval of 24 hours should elapse between applications. Preliminary bathing is unnecessary but a cleansing bath may be taken 24 hours after the last application.

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Manufacturer—Bristol Laboratories of Canada Ltd., Montreal.

Description—*Solution*—Tasteless, highly concentrated solution containing for each 10 drops: 0.5 mg. of Centrine, brand name for aminopentamide (alpha, alpha-diphenyl, gamma-dimethylaminovaleramide). *Tablets* — 0.5 mg.

Indications—A potent parasympatholytic, anticholinergic, antispasmodic agent for the treatment of gastric ulcers, duodenal ulcers, pylorospasms and hypertrophic gastritis.

Administration—2 to 5 drops in ¼ glass of water or one tablet before each meal and at bedtime. This dose may be increased daily by one or more drops of solution depending on patient's reactions and clinical response.

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Manufacturer—Mowatt & Moore Limited, Montreal.

Description—Each tablet contains: Dehydrocholic acid 3¾ gr. Spasex (homatropine methylbromide) 1/24 gr.

Indications—For symptomatic relief of gastrointestinal distress (indigestion, eructation, nausea, flatulence, constipation). Relieves spasm, stimulates biliary secretion, relaxes sphincter of Oddi, flushes biliary tract, acts as mild laxative.

Administration—One or two tablets 3 times daily or as prescribed.

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Manufacturer—Prince Regent Tar Co. Ltd., London, Eng.; *Can. Dist.*: Prescott & Company, Montreal.

Description—A saponated solution of cresol, possessing the physical characteristics of the B.P. product without the necrotic effects on the skin when used at strengths sufficient to sterilize it.

Use—As an antiseptic and germicide: Washing after infection, linen, clothing, walls, etc.—1 part in 160 parts warm water. Articles contaminated with blood, pus, etc.—soak in solution of 1 part to 40 parts warm water until matter removed; rinse in 1 part to 160 parts water.

Disinfection—1 part to 160 parts warm water. *Surgical instruments*—immerse until required in solution of 1 part to 100 parts warm water. Washing wounds, cuts—1 part to 100 parts.

VERCLYSYL 5% and 10%

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each 1,000 cc. contains: Invert sugar 50 gm. or 100 gm., thiamine HCl 10 mg., riboflavin 10 mg., nicotinamide 250 mg., pyridoxine HCl 5 mg.; vitamin B^{12} 3 mcg., in water for injection.

Indications—Conditions requiring intravenous sugar and vitamin B factors.

Administration—Intravenously.

EXOBESE

Manufacturer—Mowatt & Moore Limited, Montreal.

Description—Each capsule contains: d-Methamphetamine HCl 5 mg., vitamin A 1,500 I.U., vitamin D 150 I.U., thiamine HCl 2 mg., riboflavin 2 mg., niacinamide 10 mg., ascorbic acid 25 mg., potassium iodide 0.2 mg., methylcellulose 150 mg., interbarb (butabarbituric acid) 1/3 gr.

Indications—Adjunctive treatment of obesity.

Administration—One capsule ½ hour before breakfast and ½ hour before lunch or as prescribed.

The past is gone and static. Nothing we can do can change it. The future is before us and dynamic. Everything we do will affect it. Each day brings with it new frontiers, in our homes and in our business, if we will only recognize them. We are just at the beginning of progress in every field of human endeavor. — CHARLES F. KETTERING